National Electronic Data Interchange
Transaction Set Implementation Guide

Health Care Payer Unsolicited Claim Status

Implementation Guide Version 1.0

277

ANSI ASC X12.317
VERSION 003070

July 2002 • Draft 3

Table of Contents

1 Purpose and Business Overview

1.1 Document Purpose

In order for the health care industry to achieve the potential administrative savings with Electronic Data Interchange (EDI), standards have been developed and will need to be implemented consistently by all organizations. To facilitate a smooth transition into an EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to provide standardized data requirements and content for all users of ANSI ASC X12.317, Health Care Claim Status Notification, referred to by its identifier 277. This guide will focus on usage of the 277 by a health care payer as an unsolicited notification of claim status to a health care provider. This guide provides a detailed explanation of the transaction set by defining uniform data content and identifying valid code tables and specifying values applicable for the business focus of the unsolicited 277 claim status notification. The intention of the developers of the 277 is represented in the guide.

This implementation guide is designed to help those who send or receive claim status information in the 277 format.

Health Care Providers receiving the 277 include, but are not limited to , hospitals, nursing homes, laboratories, physicians, dentists and allied professional groups. Organizations sending the 277 include insurance companies, third-party administrators, service corporations, state and federal agencies and their contractors, plan purchasers and any other entities that process health care claims.

Other business partners affiliated with the 277 include billing services, consulting services, vendors of systems, software and EDI translators, EDI network intermediaries such as clearinghouses, value-added networks and telecommunications services.

1.2 Version and Release

This implementation guide is based on the October 1996 ASC X12 standards, referred to as Version 3, Release 7, Sub-release 0 (003070). This is the first ASC X12N Guide for this business function of this transaction set. A previous tutorial is based upon Version 3, Release 4, Sub-release 0 (003040) of the 277.

1.3 Business Usage

The Health Care Claim Status Notification (277) transaction set is intended to meet the particular needs of the Health Care industry for claim status information in multiple business scenarios. The transaction set can be used as:

- a response to a Health Care Claim Status Request (276)
- a request for additional information about Health Care Claims
- an Unsolicited Health Care Claim Status Notification

This implementation guide will only address usage of the 277 as an unsolicited Health Care claim status notification. This business usage performs two functions. First, it acts as an application level acknowledgment of claims received. Second, it is used as an unsolicited listing of claims pending adjudication in a payer's system.

Separate guides have been developed detailing the usage of the 277 as an answer to a 276 and to ask for additional information about a claim.

1.3.1 Claim Application Acknowledgment

A claim application acknowledgment is used as a second level of acknowledgment for claims received electronically.

The first level of acknowledgment usually concentrates on the syntax or structure of the submission received. For an ASC X12 Health Care Claim (837) this first level is a Functional Acknowledgment (997) transaction. The 997 concerns itself only with the ability or inability of the receiver to understand the entire claim transaction.

The second level, the application acknowledgment, is a report of the business validity and acceptability of the individual claims. The 277 can be used independent of the format of the original claim. Usually, the data for this 277 is generated by a pre-adjudication editing program. The Application Acknowledgment identifies those claims that are accepted for adjudication, as well as those that are rejected. The 277 transaction is the only notification of pre-adjudication rejection of claims. Claims rejected at this stage of the business process are never reported in a Health Care Claim Payment/Advice (835) transaction.

Claims that are missing necessary information are either rejected, or accepted as pending at this stage. The actual request for the additional information is outlined in the Health Care Claim Status Request for Additional Information implementation guide and is considered to be generated by the adjudication system.

The rejection of claims after being pended in the Application Acknowledgment 277 is accomplished in the 835 transaction. See the Health Care Claim Payment/ Advice implementation guide for details.

1.3.2 Pended Claim Listing

The Pended Claim Listing provides an acknowledgment to the provider of all claims still in the adjudication system which are not finalized, paid or denied. This usage attempts to supply the provider with claim status without the provider initiating a specific request for the information. The Pended Claim listing is an optional addition to the Health Care Claim Payment/Advice (835) transaction. The 835 lists all claims that have been finalized, paid or denied, by the adjudication system. Usage of this business application of the 277 should minimize or eliminate the use of the Claim Status Request and Response pair.

1.4 Information Flows

Figure 1 illustrates the flow of information related to all usages of the Health Care Claim Status Notification.

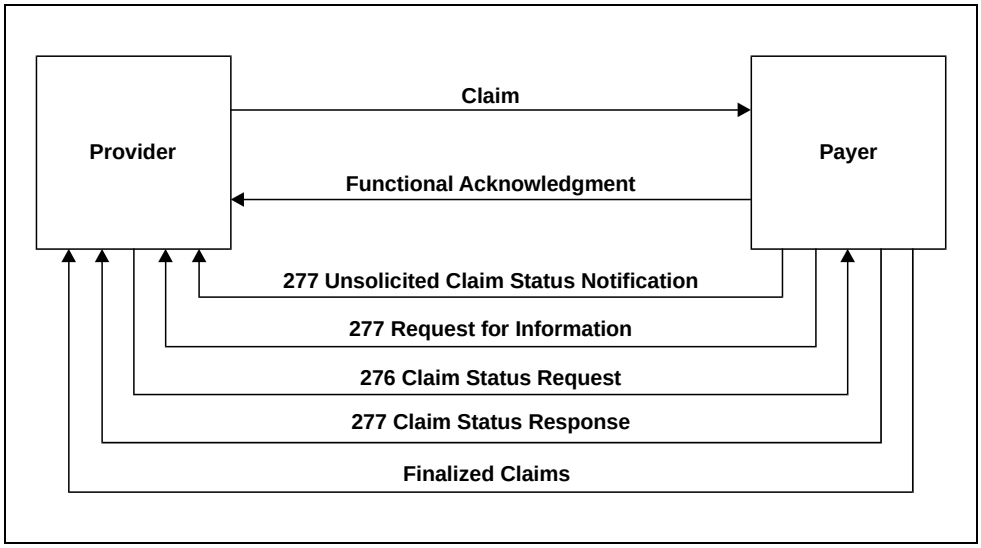


Figure 1. General Claim Status Information Flow

Figure 2 illustrates the flow of information for the Claim Status Notification as a claim application acknowledgment.

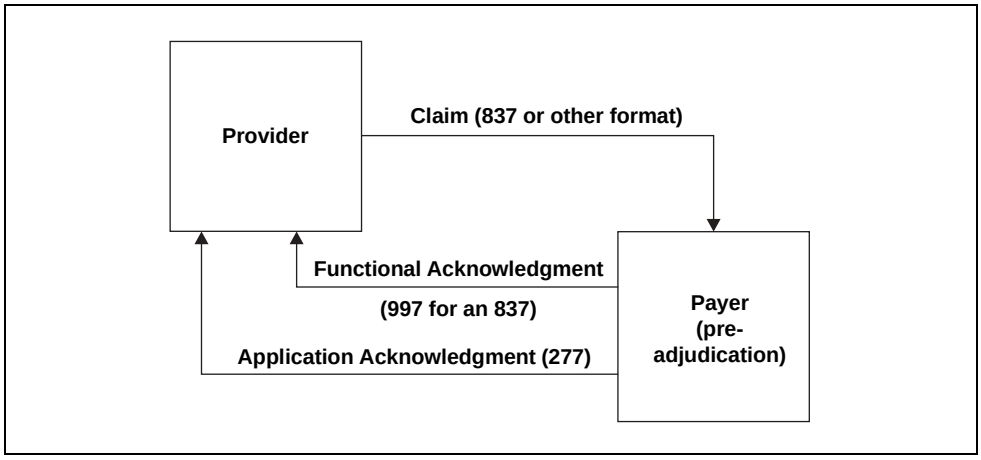


Figure 2. Information Flow as Claim Appl. Acknowledgment

Figure 3 illustrates the flow of information for an unsolicited pended claim list.

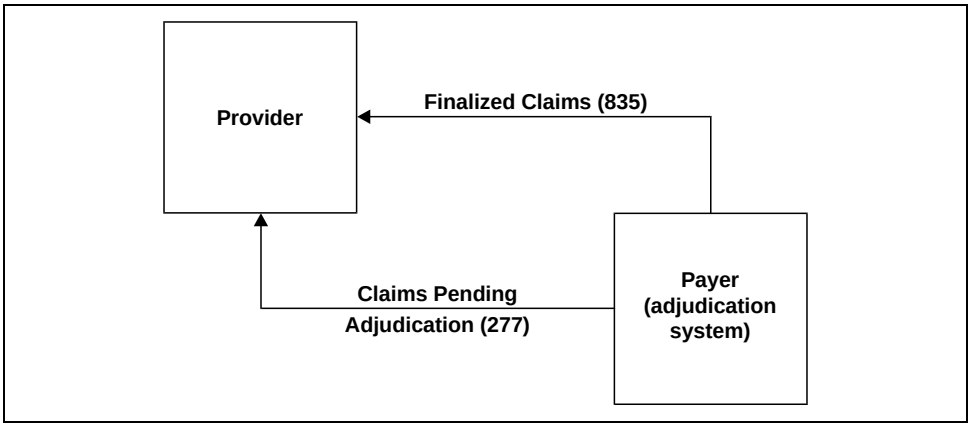


Figure 3. Information Flow as Pended Claim List

2 Data Overview

2.1 Overall Data Architecture

NOTE
For a review of the transaction set structure including descriptions of segments, data elements, levels, and loops, see ***Appendix A, ASC X12 Nomenclature.***

2.1.1 Claim Status Notification

The 277 is used to transmit information to claim submitters, such as health care providers and billing services, regarding actions taken on a specific claim and/or line item. Claim status is the location of the claim within the payer's claim processing and adjudication system (Status includes the steps of acceptance or rejection of a claim into the payer's system; suspension, pending and payment or denial). Claim status also allows payers to specify the reason(s) for suspension, rejection, or denial of a claim and/or line item. A provider, its agent or billing service may request claim status, or applications within the payer's claim processing system may furnish the information to the provider on a regular schedule.

2.1.2 Health Care Payer Unsolicited Claim Status Notification

In the Unsolicited Claim Status Notification, the reporting is initiated by the payer, its agent or its service bureau. An application within the payer's claim processing system activates the transaction. Examples include, notification of receipt into the adjudication system, a list of claims awaiting final adjudication or a list of claims that are suspended. The business function of requesting additional information for suspended claims is covered in a separate implementation guide.

Since the 277 can be used with various applications within a claim processing system, payers should verify their data needs and those of the information receiver prior to implementation.

2.1.2.1 Claim Application Acknowledgment

The 277 is used to report the business validity and acceptability of individual claims submitted to the payer. Typically, this is through a pre-adjudication editing program known as the "front-end." The 277 application acknowledgment may report not only the acceptance or rejection of a claim into the adjudication system, but it may also provide reasoning for return of the claim to the submitter. Some payers report missing information only, and others conduct relational editing between fields at this stage. For example, the payer may return the claim and simply notify the provider via a 277 that information was missing and invalid; however, to encourage more accurate claims in the future and to aid the provider in submitting a correct claim, the payer has the capability in the 277 to specify which data elements are missing and invalid. Some claim processing systems conduct relational edits prior to claims entering the adjudication system. For example, verification of the subscriber name and identifier or the relationship between data fields may occur. Claim status codes specify the missing data, the reasons for rejection or the acceptance of the claim into the adjudication system.

2.1.2.2 Pended Claim Listing

The Pended Claim Listing provides a notification to the submitter of all claims still in the adjudication process but which are not finalized, paid, or denied. The pended claim listing may also provide information for claims which have suspended for additional information or review. It does not make the request for information from the provider or submitter. Since no payment information or requests are included in the transaction, the messages to the providers tend to be simple status.

2.1.3 Claim Status Information

Status information may be reported at either the claim or the line item level using the Status Information (STC) segment. The STC segment reports the status, the effective date of the status, and the amount of original submitted charges. Additionally, free form text is allowed, but not recommended. In the unsolicited notification, no payment amounts, paid dates, or check issue dates are included.

The payer refers the provider to the claim in several trace and reference numbers to facilitate matching and retrieval in the provider's internal systems. The trace number (TRN) is the claim submitter's identifier, also known as the provider's patient control number. This is the provider's primary key to its internal patient records system, and it is required on all claim submissions to payers. In the 837 Claim, this information is submitted in CLM01, the Claim Submitter's Identifier. Other examples are - from HCFA 1500 paper forms this information comes from Box 25, from HCFA 1500 National Standard Format record CA0 - field 03, from UB92 Paper format form locator 3, and UB92 electronic format RT20-03. The secondary key is the payers internally assigned number, if the claim was accepted into the adjudication system. This is commonly known as an internal control or document control number (ICN/DCN). This is referred to in the reference identification (REF) segment. The Payer's ICN/DCN should be included in any further inquiries or communications with the payer, whether electronic, paper or voice. Payers or Clearinghouses processing claims for multiple lines of business (LOB) may require the LOB on the Health Care Claim Status Request. The TRN04, the source of payment, is used for this purpose. The provider populates TRN04 using the same data value placed on the original claim to indicate which line of busi-

ness, e.g. Medicare, Champus, Blue Cross/Blue Shield they were billing at that time. As with TRN02, TRN04 is originally identified by the provider in the billed claim and returned by the payer in subsequent communications regarding the claim. Within the TRN segment TRN01 is used to indicate the Trace Type Code is the Referenced Transaction Trace Number. TRN02 is the Reference Identification described as the Patient's control number supplied by the originator of the claim. Within health care transactions, this data value is found on the paper UB92 in Form Locator 3, electronic UB92 in RT20-03, paper HCFA 1500 form in Block 26, in HCFA NSF in record CA0 field 03, and in the 837 transaction from CLM02. TRN04 identifies the anticipated source of payment. Within health care transactions, this data value is found on the paper UB92 in Form Locator 50, electronic UB92 in RT30-04, Paper HCFA 1500 form in Block 1 in HCFA NSF in record CA0 field 23 and in the 837 transactions from CLM03.

In addition to reference and trace numbers, the payer transmits to the provider information such as the subscriber and patient names and identifiers, service dates, revenue and procedure codes, and the originally submitted charges, as applicable. This information not only serves as a secondary verification of reference numbers, but it may also indicate to the provider the invalid information.

Claim status can be provided at the claim and line item level. For claim level information, loop 2200 is used in hierarchical levels (Subscriber) 22 and (Dependent) 23. Service line information can be indicated in the 2220 loop at both hierarchical levels 22 and 23. In both loops, the STC segment is allowed one iteration. Since no information is being returned to the payer from the submitter or provider, loops 2210 and 2225, which include administrative contact information, are not included in this implementation guide.

2.1.4 Health Care Claim Status Reason Codes

In the STC segment, data elements STC01, STC10 and STC11, Health Care Claim Status, are composite elements which use industry codes from source 310, Health Care Claim Status/Reason Code List. The list is maintained by a committee of health care industry representatives from payer, provider, and vendor organizations, and it is updated after each ANSI ASC X12 trimester meeting. The Blue Cross Blue Shield Association is the maintainer of the list, and the primary distribution source is the Washington Publishing Company world wide web site (www.wpc-edi.com). Those unable to access the Internet may contact the Blue Cross Blue Shield Association (BCBSA) directly at (312) 440-0623.

The Health Care Claim Status composite code consists of two elements from the BCBSA code lists and one ASC X12 code. Each code is alphanumeric. The intent of the composite structure is to promote flexibility in the claim status messages. That is, the same information (e.g., a patient name, patient identification, coverage determination, etc.) may be used in an acknowledgment, as a reason for rejection or nonpayment of services or may be requested to complete claim processing. Separating the specific message from the type of claim status (i.e., acknowledgment, pending, request for information, or finalized) reduced the number of necessary codes as well as the burden for maintaining the code list.

Additionally, ASC X12 data element 98 (Entity Identifier Code) may be used with the industry code combination to further define the service or entity described in the status message. Inclusion of data element 98 promotes the development of more generic messages, thereby increasing the flexibility of the claim status codes.

The first code in the composite is the Health Care Claim Status Category Code. The category code indicates the level of processing achieved by the claim. The categories include acknowledgment, pending, finalized, or requests for additional information.

The second code is the Health Care Claim Status Message. The status message provides more specific information about the claim or line item. Examples of status messages include “awaiting next periodic adjudication cycle,” “entity not eligible for benefits for submitted dates of service,” and “charges for pregnancy deferred until delivery.”

The third code in the composite is ASC X12 data element 98 (Entity Identifier Code). The entity identifier code should be used only to further clarify the message of the category and the status message codes. Appropriate values in the code list describe types of providers, services, facility types and other health care related entities. Data element 98 is required with those messages which refer to an “entity” in the code narrative description. A list of appropriate code values for data element 98 is within the STC segment in Section 3.

Examples of the composite claim status code in STC01, STC10 and STC11 follow (the “:” in the codes below represents the composite element separater:

Code	Description
A3:21	Acknowledgment/Rejection: Missing or invalid information
A3:21:DN	Acknowledgment/Rejection: Missing or invalid information: Referring provider

The STC segment allows for three claim status composite codes. Multiple claim status codes contained in an STC segment may provide different information or be used in conjunction with one another. Examples of multiple claim status codes relating to one another follow:

Example one:

Code	Description
A3:21	Acknowledgment/Rejection: Missing or invalid information
A3:120	Acknowledgment/Rejection: TPO rejected claim/line because claim does not contain enough information
A3:133:DN	Acknowledgment/Rejection: Entity’s UPIN: Referring provider

Example two:

Code	Description
A3:21:DN	Acknowledgment/Rejection: Missing or invalid information: Referring provider
A3:157:QC	Acknowledgment/Rejection: Entity’s Gender: Patient
A3:86	Acknowledgment/Rejection: Diagnosis and patient sex mismatch

If more than three composite codes are needed to provide all information on a claim’s status in the claim processing system, the STC may be repeated by reiterating loop 2200.

2.2 Data Usage by Business Usage

This *Health Care Payer Unsolicited Claim Status Notification* implementation of the 277 transaction set is divided into two tables, Header and Detail. See *Section 3, Transaction Set,* for a description of the following presentation format.

Table 1, the Header level, identifies the transaction set and specifies the business purpose and data hierarchy of the current transmission.

Table 2, the Detail level, contains specific information about the information source, the information receiver, the provider of service, the subscriber, the dependent, and the claim status.

2.2.1 HL Levels in the *Health Care Payer Unsolicited Claim Status Notification*

Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	

Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	HL	Hierarchical Level	M	1	
020	SBR	Subscriber Information	O	1	
030	PAT	Patient Information	O	1	
		LOOP ID - 2100			**>1**
050	NM1	Individual or Organization Name	R	1	
060	N3	Address Information	O	2	
	...				

Figure 4. Transaction Set 277

Several ASC X12 transaction set standards employ a data-structure called “hierarchical levels” (HLs). Typically, HLs give implementers some choice of how to group data within a transaction set (appropriate grouping and sequencing of data can reduce the transmission of repetitive data).

The ASC X12 standard for the 277 transaction set allows for several different hierarchical level structures in table 2. However, this implementation guide limits *Health Care Payer Unsolicited Claim Status Notification* implementations to a single uniform structure. This structure is specified by code value **0010** in data element **BHT01**, and consists of five hierarchical levels (HLs), numbered from HL1 to HL5:

The HL1 level is the highest hierarchical level. HL1 defines the information source. This is the entity that is the decision maker in this business.

The HL2 level is the second level. HL2 defines the information receiver. One or more HL2 levels can be nested within an HL1 level.

The HL3 level is the third level. HL3 defines the provider of service. One or more HL3 levels can be nested within an HL2 level.

The HL4 level is the fourth level. HL4 defines the subscriber. One or more HL4 levels can be nested within an HL3 level.

The HL5 level is the lowest hierarchical level. HL5 defines the dependent (patient). Zero or more HL5 levels can be nested within an HL4 level.

2.2.1.1 HL1 - Information Source Level

The HL1 level uniquely identifies an information source by name and identifier code. The information source is the entity holding the claim status information.

Each 277 transaction set transmitted from an information source will contain a single HL1 level for itself. However, a 277 transaction set transmitted from a clearing house or service bureau to an information receiver could contain an HL1 level for each of several information sources.

Detail - Information Source

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	HL	Information Source	M	1	
		LOOP ID - 2100			**>1**
050	NM1	Payer Name	R	1	
060	N3	Payer Street Address	O	2	
070	N4	Payer City/State/Zip	O	1	

Figure 5. Information Source Level

2.2.1.2 HL2 - Information Receiver Level

The HL2 level uniquely identifies the information receiver by name and identifier code. The information receiver is the entity receiving and using the claim status information from the information source.

A 277 transaction set received by an information receiver will contain only HL2 levels identifying itself. However, a 277 transaction set transmitted from an infor-

Detail - Information Receiver

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	HL	Information Receiver	M	1	
		LOOP ID - 2100			**>1**
050	NM1	Information Receiver Name	R	1	
060	N3	Information Receiver Street Address	O	2	
070	N4	Information Receiver City/State/Zip	O	1	

Figure 6. Information Receiver Level

mation source to a clearing house or service bureau could contain an HL2 level for each of several information receivers.

2.2.1.3 HL3 - Provider of Service Level

The HL3 level uniquely identifies the provider of service by name and identifier code. The provider of service is the person or entity which provided the service described in the health care claim for which status information is conveyed.

An information source may generate multiple iterations of this level when transmitting information for multiple providers of service to the same information receiver.

Detail - Provider of Service

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	HL	Provider of Service	M	1	
		LOOP ID - 2100			**>1**
050	NM1	Provider Information	R	1	

Figure 7. Provider of Service Level

2.2.1.4 HL4 - Subscriber Level

The HL4 level uniquely identifies the subscriber by name and identifier codes. The subscriber is the individual on behalf of whom health insurance benefits are maintained. The HL4 level may also contain claim status information when the subscriber is also the patient in the claim.

Detail - Subscriber

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	HL	Subscriber	M	1	
		LOOP ID - 2100			**>1**
050	NM1	Subscriber Name	R	1	
060	N3	Subscriber Address	O	2	
070	N4	Subscriber City/State/Zip	O	1	
		LOOP ID - 2200			**>1**
090	TRN	Claim Submitter's Identifier	O	1	
100	STC	Claim Level Status Report	R	1	
110	REF	Payer Claim Control Number	O	3	
110	REF	Reference Identification	O	3	
110	REF	Reference Identification	O	3	
120	DTP	Claim Service Date	O	2	
		LOOP ID - 2220			**>1**
180	SVC	Service Line Information	O	1	
190	STC	Service Line Status Information	M	1	
200	REF	Service Line Item Control Number	O	1	
210	DTP	Service Line Date	O	1	

Figure 8. Subscriber Level

An information source may generate multiple iterations of this level when transmitting information for multiple subscribers to the same provider of service.

The subscriber may have dependents who are covered under the health insurance policy. When one of these dependents is the patient, the HL5 level is used. However, when the subscriber is the (only) patient, the HL5 level is omitted and all patient and claim status information is contained in the HL4 level.

2.2.1.5 HL5 - Dependent Level

The HL5 level uniquely identifies the dependent by name and identifier codes and contains claim status information. When used the dependent is always the patient.

An information source may generate multiple iterations of this level when transmitting information for multiple dependents of the same subscriber.

When the subscriber is the only patient, the HL5 level is omitted and all patient and claim status information is contained in the HL4 level.

Detail - Dependent

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			**>1**
010	**HL**	Dependent	**M**	**1**	
		LOOP ID - 2100			**>1**
050	**NM1**	Patient Name	**R**	**1**	
060	**N3**	Patient Address	**N**	**2**	
070	**N4**	Patient City/State/Zip	**N**	**1**	
		LOOP ID - 2200			**>1**
090	**TRN**	Claim Submitter's Identifier	**R**	**1**	
100	**STC**	Claim Line Status Code	**M**	**1**	
110	**REF**	Payer's Claim Control Number / Medical Record Number	**R**	**3**	
110	**REF**	Institutional Type of Bill	**O**	**3**	
110	**REF**	Medical Record Number	**O**	**3**	
120	**DTP**	Claim Service Date	**A**	**2**	
		LOOP ID - 2220			**>1**
180	**SVC**	Service Line Information	**O**	**1**	
190	**STC**	Service Line Status Information	**M**	**1**	
200	**REF**	Claim Line Item Control	**A**	**1**	
210	**DTP**	Claim Service Date	**A**	**1**	

Figure 9. Dependent Level

2.2.2 Claim Identification

When conveying claim status information, the information source and information receiver must exchange enough data to identify the claim to which the status applies. This is accomplished by transmitting the claim identifier used by each party.

The claim identifier used by the information receiver is conveyed in data element *TRN02, Claim Submitter's Identifier (provider's patient control number),* at position 090 of table 2 in level HL4 or level HL5. This will be the identifier submitted with the original claim in data element *CLM01, Claim Submitter's Identifier,* at position 130 of table 2 of the 837 transaction set. This data is found on the paper

UB92 in Form Locator 3, electronic UB92 in RT20-03, paper HCFA 1500 form in Block 26, in HCFA NSF in record CA0 field 03.

The claim identifier used by the information source is conveyed in the REF *(Payer' Claim Number)* data segment at position 110 of table 2 in level HL4 or level HL5. This REF *(Payer' Claim Number)* data segment may be omitted for rejected claims.

2.3 Interaction With Other Transactions

2.3.1 Claim Application Acknowledgment Interactions

As an application acknowledgment, there can be a direct relationship between particular 277 and a particular claim submission (837 or other format). While not necessary to maintain this relationship, it should be considered good business to acknowledge a single claim submission in a single 277 transaction. Whether or not this relationship is retained, data relationships between the claim and the status must be maintained. The Claim Submitter's Identifier, known as the patient account number, reported in the claim is returned in the 277 as the trace number. The Claim Submitter's Identifier is located in the 837 in CLM01. In the 277, the Claim Submitter's Identifier, or other provider supplied identifier, located in the table 2, position 090 TRN02 of the Hierarchical level (HL) for the patient (subscriber or dependent, as appropriate).

2.3.2 Pended Claim Listing Interactions

When used as a pended claim listing, there is no direct correlation between a particular 277 and a particular claim submission. The claims in the 277 will frequently be from multiple claim submissions. In addition, finalized claims from those claim transmissions will be, or have been, reported in an 835 transaction. It is still necessary to report back the Claim Submitter's Identifier from the claim. The Claim Submitter's Identifier will be found in the table 2, position 090 TRN02 of the Hierarchical level (HL) for the patient (subscriber or dependent, as appropriate).

The claim indentifier used by the information source is conveyed in data element REF02, Payer's Claim Number, at position 110 of table 2 in HL4 (subscriber) or level HL5 (dependent).

2.4 Transaction Type and Purpose

With the 277 transaction performing multiple functions, it is necessary to identify the specific purpose of each transaction early. This identification will determine how the data in the transaction will be handled by the receiving applications. Identification of the business function occurs in the Functional Group Header (GS) segment and in the Beginning of Hierarchical Transaction (BHT) segment.

Additional identification of the business purpose of multi-functional transaction sets is made in the Functional Group Header segment or GS. See Appendix A for a detailed description of the elements in the GS segment.

In the BHT segment, the first element (Transaction Set Purpose Code) and the sixth element (Transaction Set Type Code) identify the specific business use of the transaction. When the 277 is used as a claim application acknowledgment, the Purpose code value used will be 08, “Status”, and the Type code value will be TH, “Receipt Acknowledgment Advice”. When the 277 is used as a Pended Claims List, the Purpose code value will be 08, “Status”, and the Type code value will be NO, “Notice”. See the detailed description of the BHT segment in section 3 for more information.

3 Transaction Set

3.1 Presentation Examples

NOTE
For a review of transaction set structure including descriptions of segments, data elements, levels and loops, see ***Appendix A, ASC X12 Nomenclature.***

The ASC X12 standards are generic in nature. For example, multiple trading communities use the same Administrative Communications Contact (PER) segment to specify contact names and phone numbers. Each community decides which elements to use and which code values in those elements apply to its business needs. All ASC X12N guides use a format that depicts both the generalized standard and the trading community specific implementation.

The transaction set detail is comprised of two main sections with subsections within the main sections:

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

The examples in Figures 10 through 15 define the presentation of the Transaction Set which follows.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	010	ST	835 Header	R	1	
54	020	BPR	Financial Information	R	1	
60	040	TRN	Reassociation Key	R	1	
62	050	CUR	Non-US Dollars Currency	O	1	
65	060	REF	Receiver ID	O	1	
66	060	REF	Version Number	O	1	
68	070	DTM	Production Date	O	1	
			PAYER NAME			1
70	080	N1	Payer Name	R	1	
72	100	N3	Payer Address	O	1	
75	110	N4	Payer City, State, Zip	O	1	
76	120	REF	Additional Payer Reference Number	N	1	
77	130	PER	Payer Contact	O	1	
			PAYEE NAME			1
79	080	N1	Payee Name	R	1	
81	100	N3	Payee Address	N	1	
82	110	N4	Payee City, State, Zip	N	1	
84	120	REF	Payee Additional Reference Number	O	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

Segment repeats and loop repeats reflect actual usage

R=Required
A=Advised
O=Optional
N=Not Advised

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 10. Transaction Set Key - Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix A, ASC X12 Nomenclature* for a complete description of the standard

See *Appendix A, ASC*

835 Health Care Claim Payment/Advice

Functional Group ID: HP

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	

Figure 11. Transaction Set Key - Standard

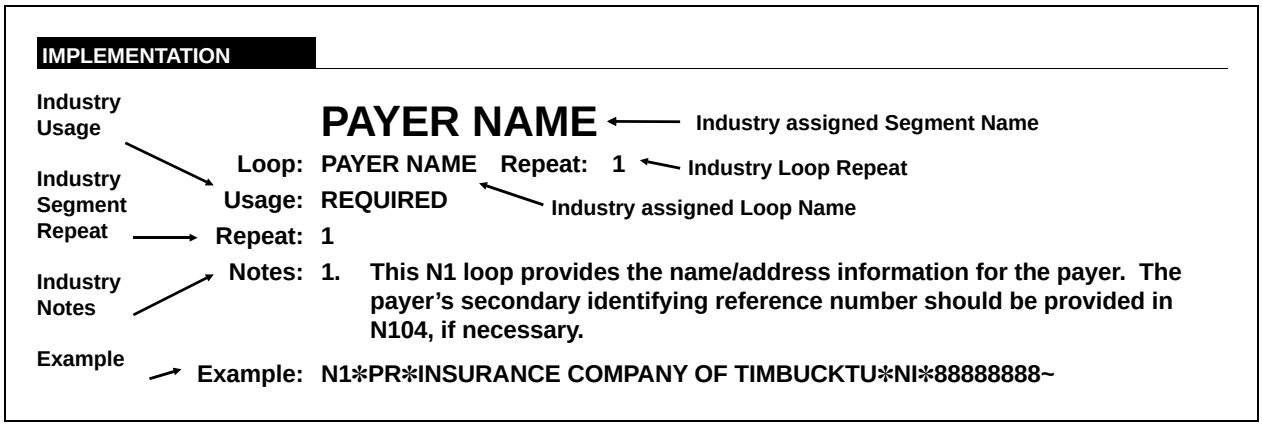


Figure 12. Segment Key - Implementation

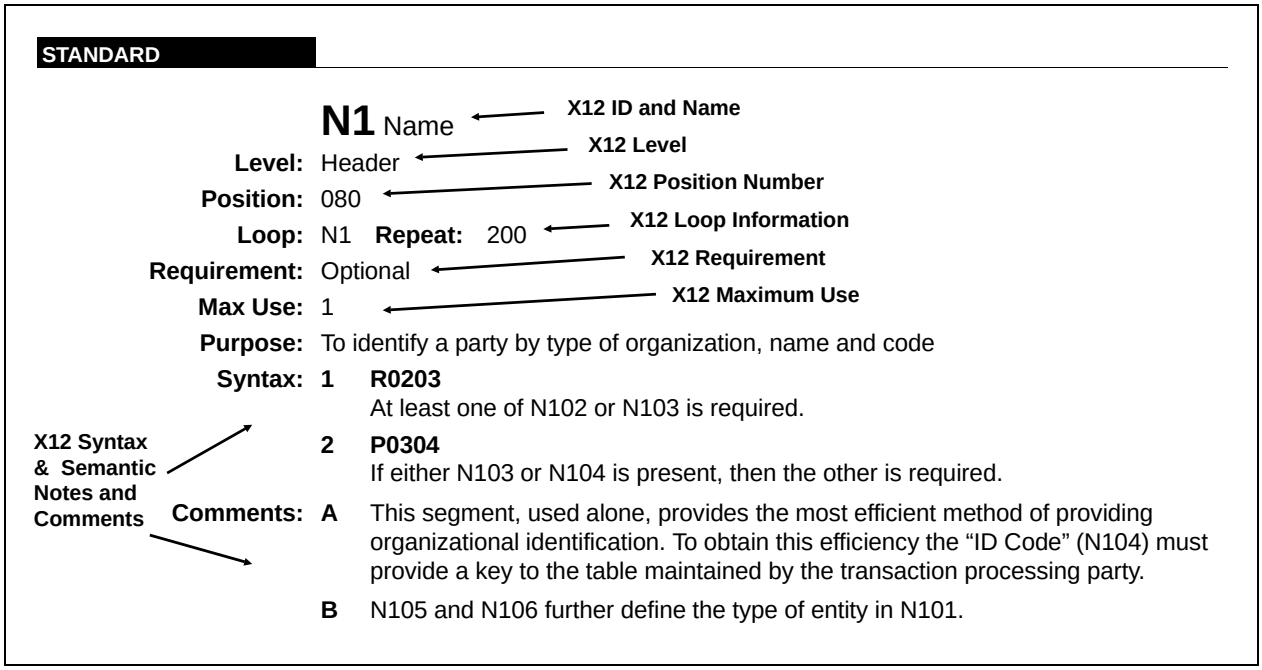


Figure 13. Segment Key - Standard

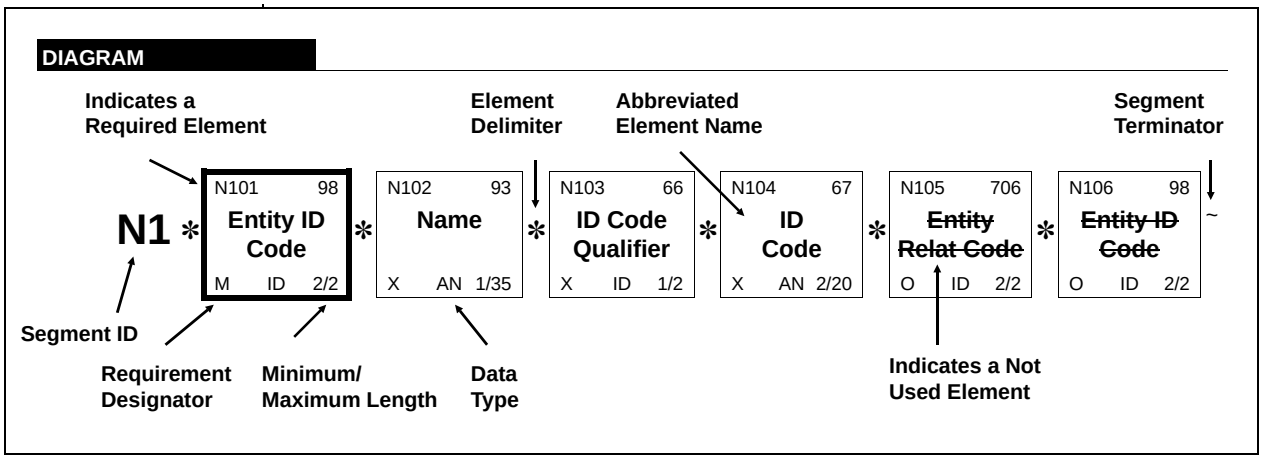


Figure 14. Segment Key - Diagram

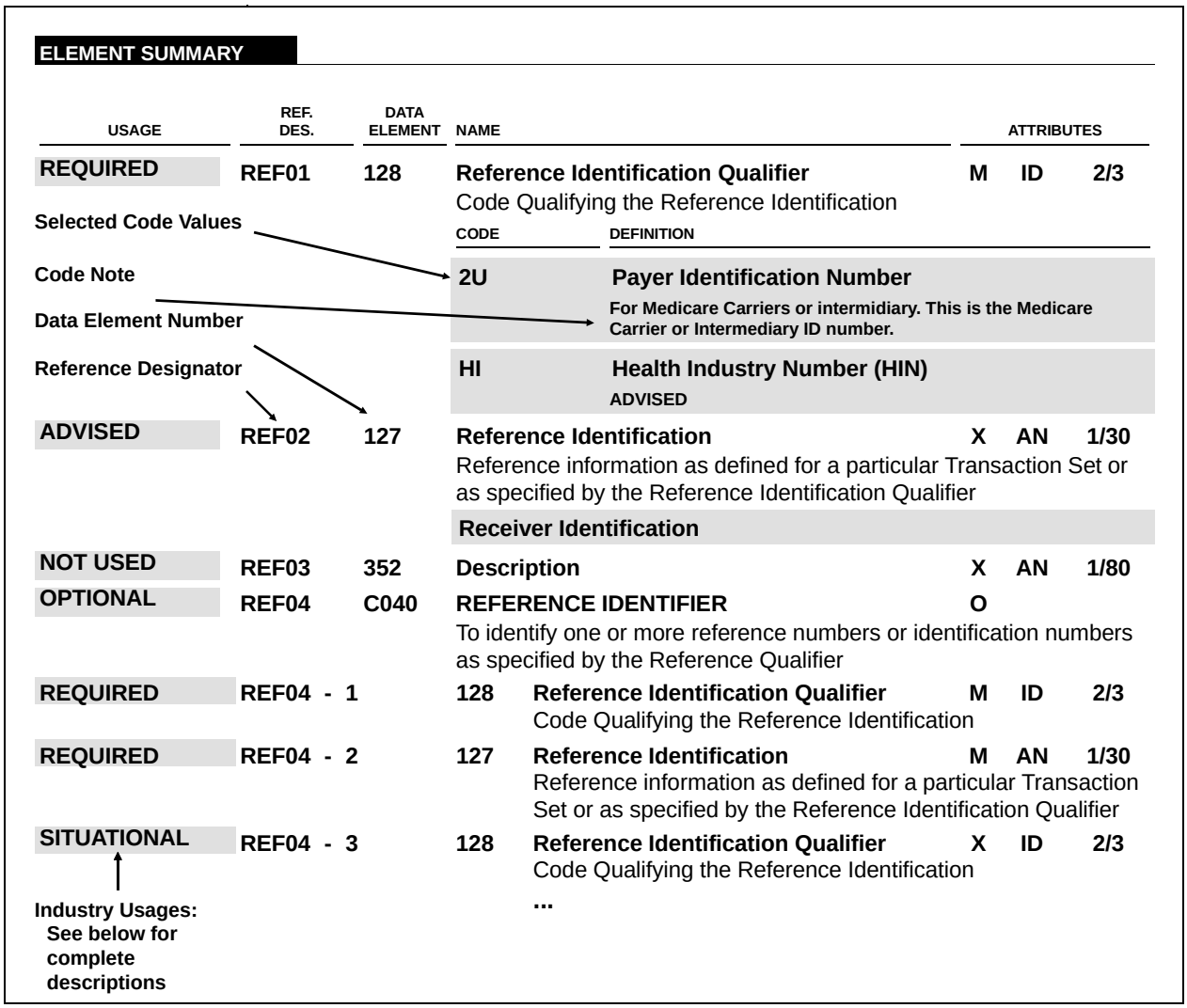


Figure 15. Segment Key - Element Summary

Industry Usages:

Required	This item must be used to be compliant with this implementation guide.
Advised	Use of this item is preferred or recommended.
Not advised	Use of this item should be avoided whenever possible.
Not used	This item should not be used when complying with this implementation guide.
Optional	Use of this item should be determined by specific business requirements.
Situational	Use of this item is dependent on the presence or absence of other data within the transaction set. Items that have a business usage of required, advised, or optional may have an X12 designation of relational, which establishes a dependency on the presence or absence of another item.

IMPLEMENTATION

277 Health Care Claim Status Notification

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
27	010	ST	277 Header	R	1	
28	020	BHT	Transaction Structure	R	1	

Table 2 - Information Source Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE			1
30	010	HL	Information Source	R	1	
			LOOP ID - 2100A PAYER NAME			1
32	050	NM1	Payer Name	R	1	
34	060	N3	Payer Street Address	S	2	
35	070	N4	Payer City/State/ZIP	S	1	

Table 2 - Information Receiver Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER			1
36	010	HL	Information Receiver	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
38	050	NM1	Information Receiver Name	R	1	
40	060	N3	Information Receiver Street Address	S	2	
41	070	N4	Information Receiver City/State/ZIP	S	1	

Table 2 - Provider of Service Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PROVIDER OF SERVICE			>1
42	010	HL	Provider of Service	R	1	
			LOOP ID - 2100C PROVIDER INFORMATION			1
44	050	NM1	Provider Information	R	1	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D SUBSCRIBER			**>1**
46	**010**	**HL**	Subscriber	**R**	**1**	
			LOOP ID - 2100D SUBSCRIBER NAME			**1**
48	**050**	**NM1**	Subscriber Name	**R**	**1**	
50	**060**	**N3**	Subscriber Address	**S**	**2**	
51	**070**	**N4**	Subscriber City/State/ZIP	**S**	**1**	
			LOOP ID - 2200D CLAIM SUBMITTER'S IDENTIFIER			**>1**
53	**090**	**TRN**	Claim Submitter's Identifier	**S**	**1**	
55	**100**	**STC**	Claim Level Status Information	**R**	**1**	
60	**110**	**REF**	Payer's Claim Control Number	**S**	**1**	
62	**110**	**REF**	Institutional Type of Bill	**S**	**1**	
64	**110**	**REF**	Medical Record Number	**S**	**1**	
66	**120**	**DTP**	Claim Service Date	**S**	**2**	
			LOOP ID - 2220D SERVICE LINE INFORMATION			**>1**
67	**180**	**SVC**	Service Line Information	**S**	**1**	
70	**190**	**STC**	Service Line Status Information	**R**	**1**	
75	**200**	**REF**	Service Line Item Control Number	**R**	**1**	
76	**210**	**DTP**	Service Line Date	**S**	**1**	

Table 2 - Dependent Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000E DEPENDENT			**>1**
77	**010**	**HL**	Dependent	**S**	**1**	
			LOOP ID - 2100E PATIENT NAME			**1**
79	**050**	**NM1**	Patient Name	**R**	**1**	
81	**060**	**N3**	Patient Address	**S**	**2**	
82	**070**	**N4**	Patient City/State/ZIP	**S**	**1**	
			LOOP ID - 2200E CLAIM SUBMITTER'S IDENTIFIER			**>1**
83	**090**	**TRN**	Claim Submitter's Identifier	**R**	**1**	
85	**100**	**STC**	Claim Line Status Information	**R**	**1**	
90	**110**	**REF**	Payer's Claim Control Number	**S**	**1**	
92	**110**	**REF**	Institutional Type of Bill	**S**	**1**	
94	**110**	**REF**	Medical Record Number	**S**	**1**	
96	**120**	**DTP**	Claim Service Date	**S**	**2**	
			LOOP ID - 2220E SERVICE LINE INFORMATION			**>1**
97	**180**	**SVC**	Service Line Information	**S**	**1**	
100	**190**	**STC**	Service Line Status Information	**R**	**1**	
105	**200**	**REF**	Service Line Item Control Number	**S**	**1**	
106	**210**	**DTP**	Service Line Date	**S**	**1**	
107	**270**	**SE**	Transaction Trailer	**R**	**1**	

STANDARD

277 Health Care Claim Status Notification

Functional Group ID: HN

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Status Notification Transaction Set (277) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	
030	REF	Reference Identification	O	10	
		LOOP ID - 1000			>1
040	NM1	Individual or Organizational Name	O	1	
050	N2	Additional Name Information	O	2	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	REF	Reference Identification	O	2	
090	PER	Administrative Communications Contact	O	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
010	HL	Hierarchical Level	M	1	
020	SBR	Subscriber Information	O	1	
030	PAT	Patient Information	O	1	
040	DMG	Demographic Information	O	1	
		LOOP ID - 2100			>1
050	NM1	Individual or Organizational Name	O	1	
060	N3	Address Information	O	2	
070	N4	Geographic Location	O	1	
080	PER	Administrative Communications Contact	O	1	
		LOOP ID - 2200			>1
090	TRN	Trace	O	1	
100	STC	Status Information	M	1	
110	REF	Reference Identification	O	3	
120	DTP	Date or Time or Period	O	2	
		LOOP ID - 2210			>1
130	PWK	Paperwork	O	1	
140	PER	Administrative Communications Contact	O	1	
150	N1	Name	O	1	

160	**N3**	Address Information	**O**	**1**	
170	**N4**	Geographic Location	**O**	**1**	
		LOOP ID - 2220			**>1**
180	**SVC**	Service Information	**O**	**1**	
190	**STC**	Status Information	**M**	**1**	
200	**REF**	Reference Identification	**O**	**1**	
210	**DTP**	Date or Time or Period	**O**	**1**	
		LOOP ID - 2225			**>1**
220	**PWK**	Paperwork	**O**	**1**	
230	**PER**	Administrative Communications Contact	**O**	**1**	
240	**N1**	Name	**O**	**1**	
250	**N3**	Address Information	**O**	**1**	
260	**N4**	Geographic Location	**O**	**1**	
270	**SE**	Transaction Set Trailer	**M**	**1**	

NOTES:

2/020 The SBR segment may only appear at the Subscriber (HL03=22) level.

2/030 The PAT segment may only appear at the Dependent (HL03=23) level.

2/040 The DMG segment may only appear at the Subscriber (HL03=22) or Dependent (HL03=23) level.

2/130 The 2210 loop may be used when there is a status notification or a request for additional information about a particular claim.

2/220 The 2225 loop may be used when there is a status notification or a request for additional information about a particular service line.

IMPLEMENTATION

277 HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*277*0001~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

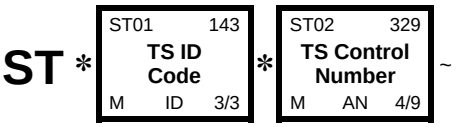
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE** **DEFINITION** **277** **Health Care Claim Status Notification**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitter could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS to GE) and interchange (ISA to IEA), but can be repeated in other groups and interchanges.**	**M AN 4/9**

IMPLEMENTATION

TRANSACTION STRUCTURE

Usage: **REQUIRED**

Repeat: **1**

Example: **BHT*0010*08*932A17*960501**TH~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 020

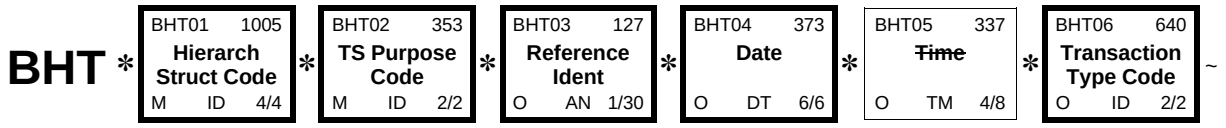
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set **0010** = **Information Source, Information Receiver, Provider of Service, Subscriber, Dependent**	**M ID 4/4**
REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set **08** = **Status**	**M ID 2/2**
REQUIRED	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SEMANTIC:** BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.	**O AN 1/30**
REQUIRED	**BHT04**	**373**	**Date** Date (YYMMDD) **SEMANTIC:** BHT04 is the date the transaction was created within the business application system.	**O DT 6/6**

NOT USED	BHT05	337	Time	O	TM	4/8
REQUIRED	BHT06	640	Transaction Type Code Code specifying the type of transaction	O	ID	2/2

CODE	DEFINITION
NO	Notice Used when function of claim status notification is to provide a list of pended claims.
TH	Receipt Acknowledgment Advice Used when function of claim status notification is to provide information about a claim in a claim processing system.

IMPLEMENTATION

INFORMATION SOURCE

Loop: **2000A — INFORMATION SOURCE** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **HL*1**20*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

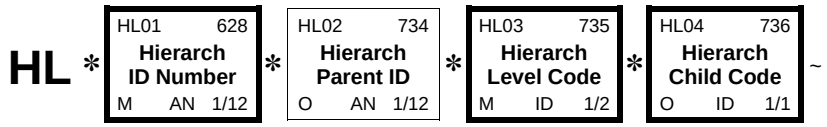
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
SITUATIONAL	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

PAYER NAME

Loop: **2100A — PAYER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*PR*2*ABC INSURANCE*****PI*12345~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

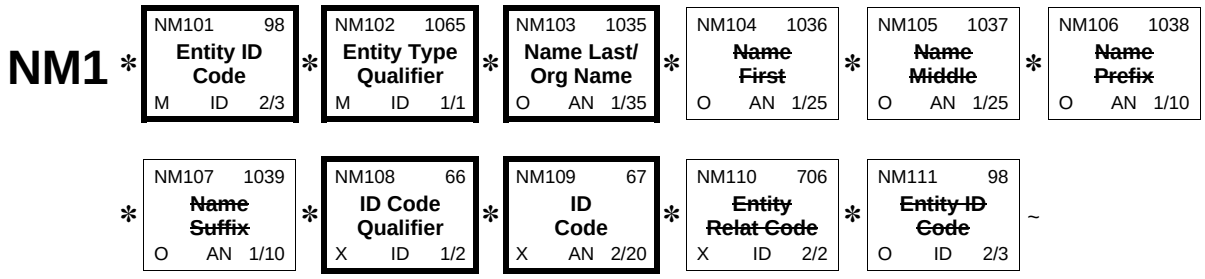
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE: **PR** — DEFINITION: **Payer**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE: **2** — DEFINITION: **Non-Person Entity**	

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
21	**Health Industry Number (HIN)**
	CODE SOURCE 121: Health Industry Identification Number
46	**Electronic Transmitter Identification Number (ETIN)**
AD	**Blue Cross Blue Shield Association Plan Code**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification**
PI	**Payor Identification**
PP	**Pharmacy Processor Number**
XV	**Health Care Financing Administration National Payer Identification Number (PAYERID)**
	CODE SOURCE 540: Health Care Financing Administration National PAYERID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809	**X**	**AN**	**2/20**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PAYER STREET ADDRESS

Loop: **2100A — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Correspondence Address.**

Example: **N3*1 SMITH STREET*SUITE 500~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

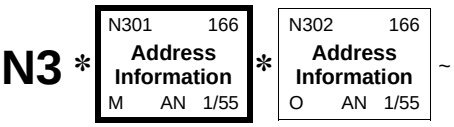
Loop: 2100

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			Used when second line of address is necessary.			

IMPLEMENTATION

PAYER CITY/STATE/ZIP

Loop: **2100A — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Example: **N4*MIAMI*FL*33131~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

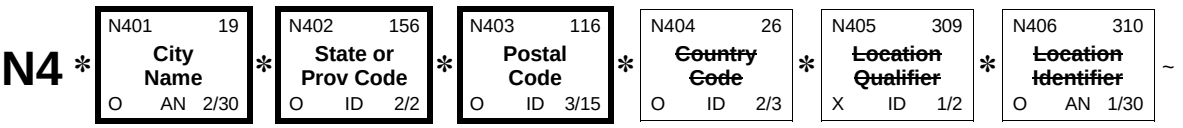
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **CODE SOURCE 51:** ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**

IMPLEMENTATION

INFORMATION RECEIVER

Loop: **2000B — INFORMATION RECEIVER** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **HL*2*1*21*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

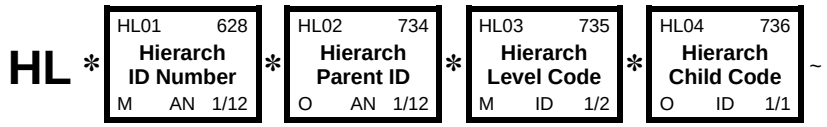
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

INFORMATION RECEIVER NAME

Loop: **2100B — INFORMATION RECEIVER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*41*2*XYZ SERVICE*****46*A222222221~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

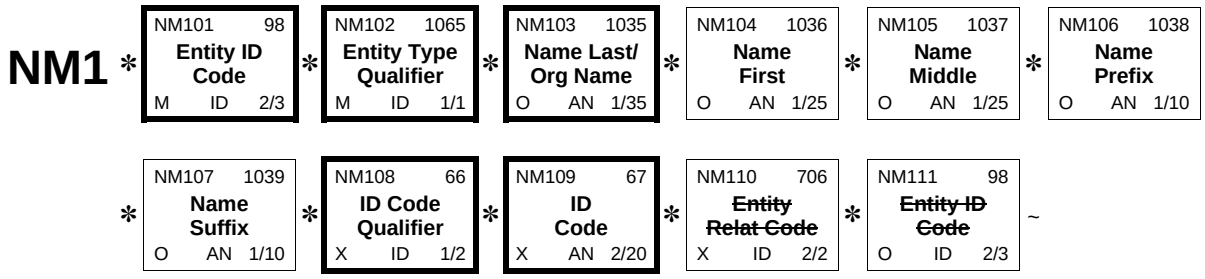
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE / DEFINITION	
			41 Submitter	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE / DEFINITION	
			1 Person	

			2	**Non-Person Entity**			
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name		**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name		**O**	**AN**	**1/25**
			Recommended when value in NM102 is 1.				
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial		**O**	**AN**	**1/25**
			Recommended when value in NM102 is 1.				
			Required if additional name information is needed to identify the Information Receiver. Recommended if the value in the entity qualifier is a person.				
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name		**O**	**AN**	**1/10**
			Recommended when value in NM102 is 1.				
			Required if additional name information is needed to identify the Information Receiver. Recommended if the value in the entity qualifier is a person.				
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name		**O**	**AN**	**1/10**
			Recommended when value in NM102 is 1.				
			Required if additional name information is needed to identify the Information Receiver. Recommended if the value in the entity qualifier is a person.				
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809		**X**	**ID**	**1/2**
			CODE	**DEFINITION**			
			46	**Electronic Transmitter Identification Number (ETIN)**			
			FI	**Federal Taxpayer's Identification Number**			
			XX	**Health Care Financing Administration National Provider Identifier**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809		**X**	**AN**	**2/20**
NOT USED	**NM110**	**706**	**Entity Relationship Code**		**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**		**O**	**ID**	**2/3**

IMPLEMENTATION

INFORMATION RECEIVER STREET ADDRESS

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Example: **N3*1234 MAIN STREET*FLOOR 5~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

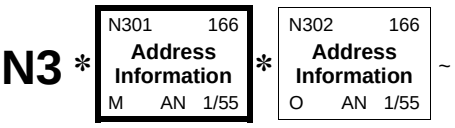
Loop: 2100

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			Used when second line of address is necessary.			

IMPLEMENTATION

INFORMATION RECEIVER CITY/STATE/ZIP

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Example: **N4*JACKSONVILLE*FL*32225~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

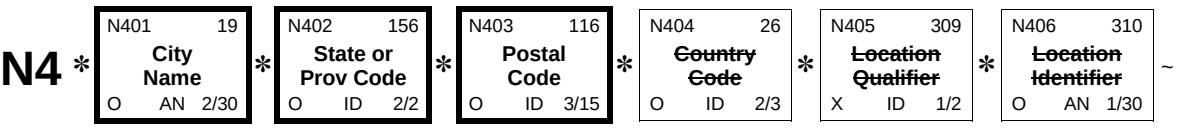
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) CODE SOURCE **51:** ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**

IMPLEMENTATION

PROVIDER OF SERVICE

Loop: **2000C — PROVIDER OF SERVICE** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. This is the Billing Provider Number.**

Example: **HL*3*2*19*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

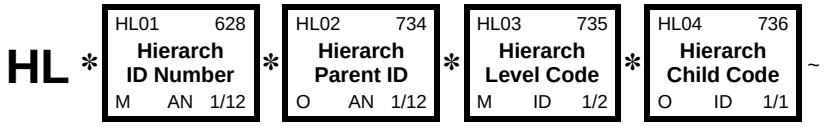
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
19	**Provider of Service**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

PROVIDER INFORMATION

Loop: **2100C — PROVIDER INFORMATION** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*1P*2*HOME MEDICAL*****SV*987666666~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

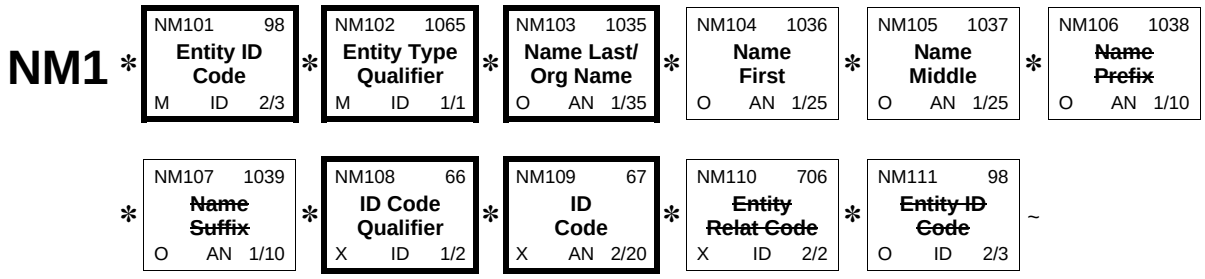
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE / **DEFINITION** **1P** — **Provider**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE / **DEFINITION** **1** — **Person**	

			2 **Non-Person Entity**			
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**
			Recommended when value in NM102 is 1. This information should always be returned when supplied on a submitted claim.			
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**
			Recommended when value in NM102 is 1. This information should always be returned when supplied on a submitted claim.			
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**
			CODE **DEFINITION** **SV** **Service Provider Number** **XX** **Health Care Financing Administration National Provider Identifier**			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809	**X**	**AN**	**2/20**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER

Loop: **2000D — SUBSCRIBER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If the subscriber and the patient are the same person, do not use the next HL(HL23) for the claim information.**

Example: **HL*4*3*22*0~ or HL*4*3*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

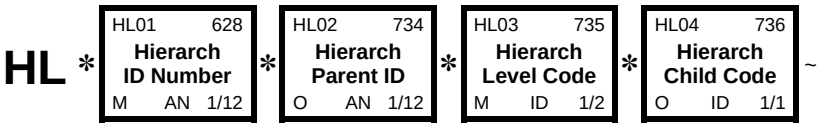
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**

Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

CODE	DEFINITION
22	**Subscriber**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2100D — SUBSCRIBER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*FRED****HN*123456789A~ or**
NM1*IL*1*SMITH*ROBERT**MI*9876543210~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

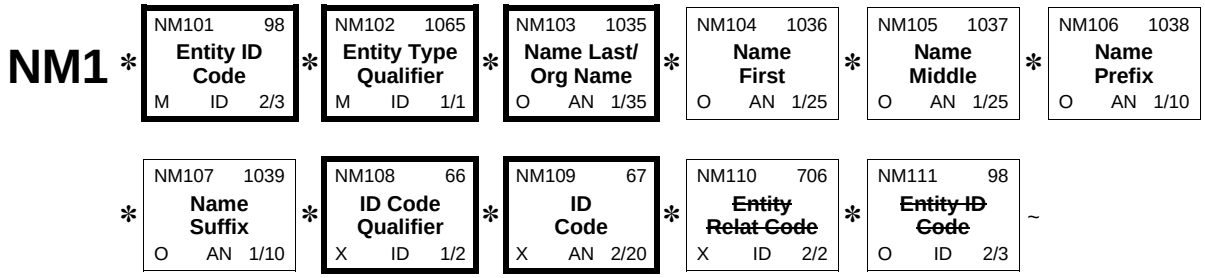
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
IL	**Insured or Subscriber**
QC	**Patient** **Use only when Subscriber is Patient.**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity** **The value "2" would be an used in an employer subscriber situation such as workers compensation. The value 'IL' would be used in NM101 for this purpose.**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **Recommended when value in NM102 is 1.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **ADVISORY:** Under most circumstances, this element is expected to be sent. **Recommended when value in NM102 is 1.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
24	**Employer's Identification Number**
CI	**CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) Identification Number**
HN	**Health Insurance Claim (HIC) Number**
MI	**Member Identification Number**
MR	**Medicaid Recipient Identification Number**
N	**Insured's Unique Identification Number**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809	**X**	**AN**	**2/20**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2100D — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. This information should be provided when it is related to the reason for rejection in claim application acknowledgemment.**

Example: **N3*123 MAIN STREET~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

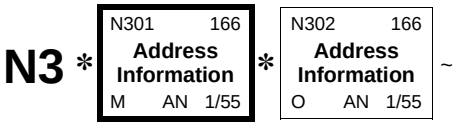
Loop: 2100

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			Used when second line of address is necessary.			

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP

Loop: **2100D — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This information should be provided when it is related to the reason for rejection in claim application acknowledgemment.**

Example: **N4*MIAMI*FL*33131~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

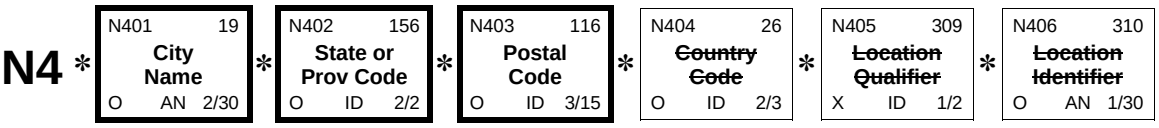
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) CODE SOURCE **51:** ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**

NOT USED	N406	310	Location Identifier	O	AN	1/30

IMPLEMENTATION

CLAIM SUBMITTER'S IDENTIFIER

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required. Used only when subscriber is patient.**
2. **The TRN segment is required by the ASC X12 syntax when Loop ID-2200 is used.**
3. **Use of this segment is required if the subscriber is the patient.**

Example: **TRN*2*SMITH123~**

STANDARD

TRN Trace

Level: Detail

Position: 090

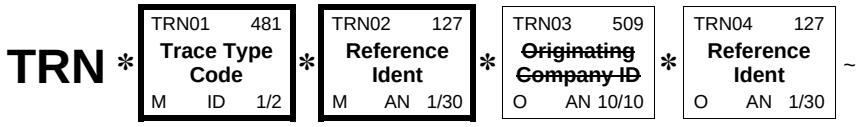
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **2 — Referenced Transaction Trace Numbers**	**M ID 1/2**
REQUIRED	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SEMANTIC:** TRN02 provides unique identification for the transaction. **Provider's Patient Control Number as supplied by originator of Claim. From : Paper UB92 - Form Locator 3. UB-92 Flat File RT 20-03. Paper HCFA 1500 Form - Block 26. ANSI 837 - CLM01. NSF - CA0-03.**	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**

SITUATIONAL **TRN04** **127** **Reference Identification** **O AN 1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

Some multiple-line of business claim payer systems require codes to indicate the line of business for which a particular claim is being routed. This is accomplished in the ASC X12N 3070 837 SBR09 data element 1032. The NSF format utilizes CA0-23.0. The HCFA 1500 paper form utilizes Block 1. The UB92 Paper form Locator 50 indicates this information, and the UB92 electronic format Record 30 field 4. The following list is a subset of data element 1032. These are values recommended to indicate the appropriate line of business when single file transmissions contain claims for multiple business lines.

10 Central Certification
12 Preferred Provider Organization (PPO)
13 Point ofService (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Risk
17 Dental Maintenance Organization
AM Automobile Medical
BL Blue Cross/Blue Shield
CH Champus
CI Commercial Insurance Co.
DS Disability
FI Federal Employees Program
HM Health Maintenance Organization
LM Liability Medical
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MH Managed Care Non-HMO
OF Other Federal Program
SA Self-administered Group
TV Title V
VA Veteran's Administration
WC Workers' Compensation Health Claim

IMPLEMENTATION

CLAIM LEVEL STATUS INFORMATION

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use of this segment is required if the subscriber is the patient.**

Example: **STC*A1:21*960501*NA*50~ or STC*A3:20*960501*15*50~**
STC*a3:247*960501*15*50~

STANDARD

STC Status Information

Level: Detail

Position: 100

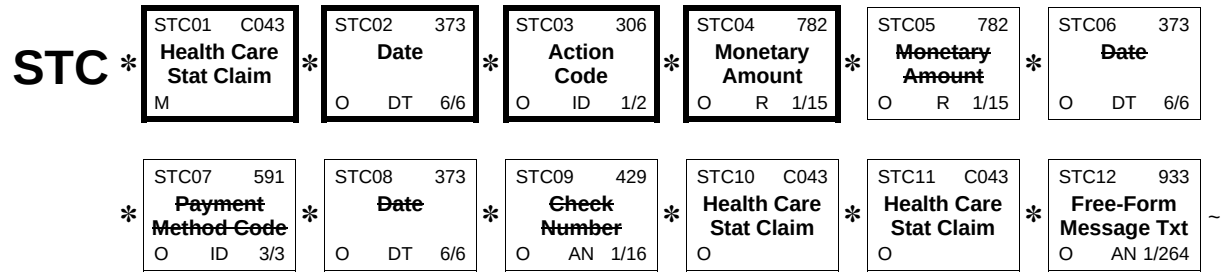
Loop: 2200

Requirement: Mandatory

Max Use: 1

Purpose: To report the status, required action, and paid information of a claim or service line

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.	**M**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	**M AN 1/30**

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

CODE SOURCE **508:** Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

CODE	DEFINITION
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1I	Preferred Provider Organization (PPO)
1P	Provider
2I	Church Operated Facility
2Q	Veterans Administration Facility
30	Service Supplier
36	Employer
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
CK	Pharmacist
CZ	Admitting Surgeon
DD	Assistant Surgeon
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E9	Participating Laboratory
EY	Employee Name

FA	Facility
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GI	Paramedic
GJ	Paramedical Company
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
OB	Ordered By
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PW	Pick Up Address
QA	Pharmacy
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QS	Podiatrist
QV	Group Practice

			RW	**Rural Health Clinic**			
			S4	**Skilled Nursing Facility**			
			SJ	**Service Provider**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TU	**Third Party Repricing Organization (TPO)**			
			TV	**Third Party Administrator (TPA)**			
			UH	**Nursing Home**			
			X5	**Durable Medical Equipment Supplier**			
REQUIRED	**STC02**	**373**	**Date** Date (YYMMDD) **SEMANTIC:** STC02 is the effective date of the status information.		**O**	**DT**	**6/6**
			Date of Status				
REQUIRED	**STC03**	**306**	**Action Code** Code indicating type of action		**O**	**ID**	**1/2**
			CODE	**DEFINITION**			
			15	**Correct and Resubmit Claim**			
			NA	**No Action Required** **Always used for pended claim list function.**			
REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** STC04 is the amount of original submitted charges.		**O**	**R**	**1/15**
			Amount of original submitted charges.				
			Some HMO Encounters will supply zero as Amount of Original Charges.				
NOT USED	**STC05**	**782**	**Monetary Amount**		**O**	**R**	**1/15**
NOT USED	**STC06**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC09**	**429**	**Check Number**		**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.		**O**		
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	**M**	**AN**	**1/30**

REQUIRED **STC10 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

CODE SOURCE **508:** Health Care Claim Status Code

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O**
Used to convey status of the entire claim or a specific service line
SEMANTIC NOTES
01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).
02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508).
03 C043-03 identifies the entity associated with the Health Care Claim Status Code.

REQUIRED **STC11 - 1** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

CODE SOURCE **507:** Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

CODE SOURCE **508:** Health Care Claim Status Code

SITUATIONAL **STC11 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

SITUATIONAL **STC12** **933** **Free-Form Message Text** **O AN 1/264**
Free-form message text

ADVISORY: Under most circumstances, this element is not sent.

SEMANTIC: STC12 allows additional free-form status information.

Only used when STC01-2 or STC10-2 or STC11-2 is equal to 448 (invalid billing code combination).

The use of this text field is limited to two specific situations. The first situation where it is acceptable to use this data element is in conjunction with Health Care Claim Status Code 448 for rejection error messages. The second situation where it is acceptable to use this data element is for periods of time when a new error rejection condition exists and the assignment of a Health Care Claim Status Code is pending. This condition should only exist between meetings of the Claims Adjustment and Claim Status Reason Code committee which maintain code lists 507 and 508 as referenced in Appendix C of this guide.

The authors strongly urge that the improper use of this field will dilute this functionality of the transaction's business purpose.

IMPLEMENTATION

PAYER'S CLAIM CONTROL NUMBER

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when used for pended claim list function.**
2. **Advised when available for claims accepted for adjudication.**
3. **This is payer's assigned control number and is to be the primary key required during an inquiry.**

Example: **REF*1K*9612991010987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

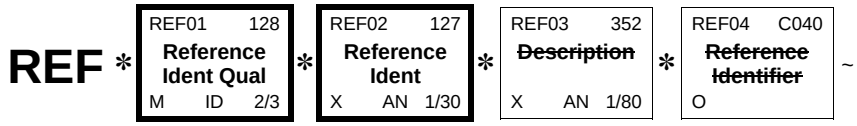
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			For example ICN, DCN, CCN.			
			CODE **DEFINITION** **1K** **Payor's Claim Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

INSTITUTIONAL TYPE OF BILL

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This is institutional type of bill on original submitted claim and is to be secondary key required during an inquiry.**

Example: **REF*BLT*111~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

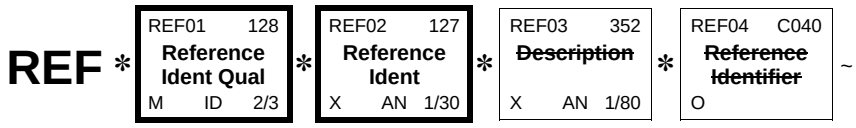
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **BLT** — **Billing Type** **Used on institutional type of bill.**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **Found in UB92 - Record 40 - Field 4** **Found in UB92 - Paper form locator 4** **Found in X12N 837 Version 3070 Segment CLM Data Element 05** **See C-9 in Appendix C**	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

MEDICAL RECORD NUMBER

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This is the medical record number as submitted on claim and should be returned when available from original claim.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

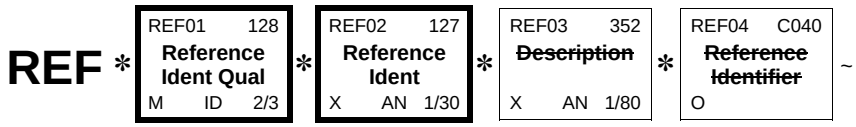
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EA** — **Medical Record Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 **Found in UB92 - Record 20 - Field 25** **Found in UB92 - Paper form locator 23** **Found in X12N 837 Version 3070 Loop 2010 Segment REF01 Qualifier EA**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200D — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **2**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

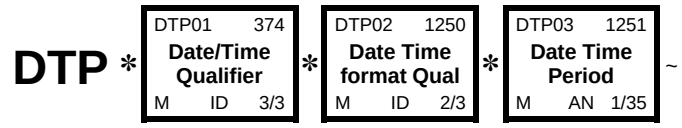
Loop: 2200

Requirement: Optional

Max Use: 2

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			CODE **DEFINITION** **472** **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **RD8** **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M AN 1/35**

IMPLEMENTATION

SERVICE LINE INFORMATION

Loop: **2220D — SERVICE LINE INFORMATION** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This loop will only be used by claim application acknowledgement when reason for rejected claim is at the service line level.**
2. **For pended claim list function this loop is not advised.**

Example: **SVC*HC:99214*50*0***1~ or SVC*NU:71X*50*0***1~**

STANDARD

SVC Service Information

Level: Detail

Position: 180

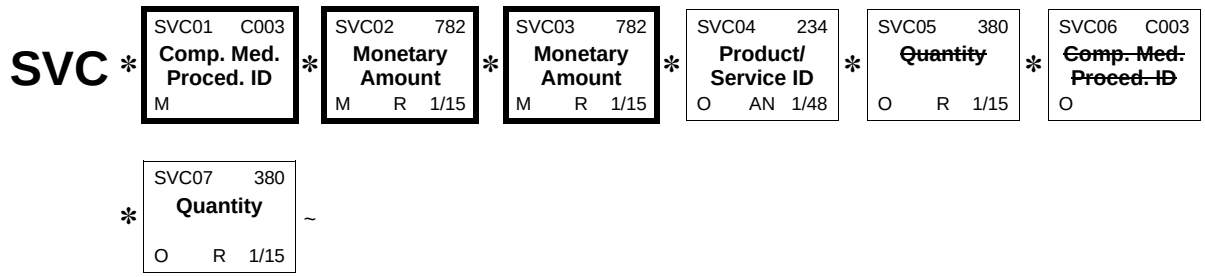
Loop: 2220 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To supply payment and control information to a provider for a particular service

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **SEMANTIC NOTES** 03 C003-03 modifies the value in C003-02. 04 C003-04 modifies the value in C003-02. 05 C003-05 modifies the value in C003-02. 06 C003-06 modifies the value in C003-02. 07 C003-07 is the description of the procedure identified in C003-02.	**M**

REQUIRED **SVC01 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

CODE	DEFINITION
A9	**Health Care Financing Administration National Standard Format Podiatry Codes**
	CODE SOURCE **265:** Health Care Financing Administration National Standard Format Podiatry Codes
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code
NU	**National Uniform Billing Committee (NUBC) UB92 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes
RB	**National Uniform Billing Committee (NUBC) UB82 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED **SVC01 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

SITUATIONAL **SVC01 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

NOT USED **SVC01 - 7** **352** **Description** **O AN 1/80**

REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/15**
			SEMANTIC: SVC02 is the submitted service charge.			
			This is submitted charge.			
REQUIRED	**SVC03**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/15**
			SEMANTIC: SVC03 is the amount paid this service.			
			Must equal zero.			
			This is the amount paid.			
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**
			SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code.			
			This is the NUBC revenue code.			
			When SVC01-1 is equal to "NU" the NUBC Revenue Code belongs in SVC01-2.			
NOT USED	**SVC05**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**
			ADVISORY: Under most circumstances, this element is expected to be sent.			
			SEMANTIC: SVC07 is the original submitted units of service.			
			This is the submitted units of service.			

IMPLEMENTATION

SERVICE LINE STATUS INFORMATION

Loop: **2220D — SERVICE LINE INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **STC*A3:110**15*65~ or STC*A3:249**15*65******A3:400~**

STANDARD

STC Status Information

Level: Detail

Position: 190

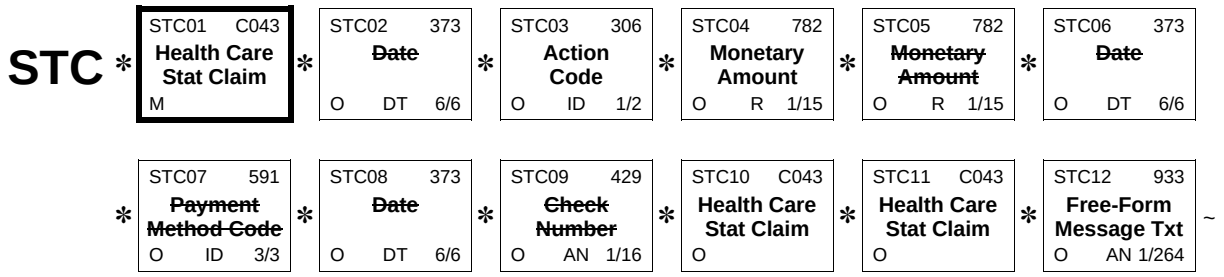
Loop: 2220

Requirement: Mandatory

Max Use: 1

Purpose: To report the status, required action, and paid information of a claim or service line

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code. **ADVISORY:** Under most circumstances, this composite is expected to be sent.	**M**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **ADVISORY:** Under most circumstances, this component is expected to be sent **CODE SOURCE 507:** Health Care Claim Status Category Code	**M AN 1/30**

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

ADVISORY: Under most circumstances, this component is expected to be sent

CODE SOURCE **508:** Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

ADVISORY: Under most circumstances, this component is expected to be sent

CODE	DEFINITION
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1I	Preferred Provider Organization (PPO)
1P	Provider
2I	Church Operated Facility
2Q	Veterans Administration Facility
30	Service Supplier
36	Employer
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
CK	Pharmacist
CZ	Admitting Surgeon
DD	Assistant Surgeon
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E9	Participating Laboratory

EY	Employee Name
FA	Facility
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GI	Paramedic
GJ	Paramedical Company
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
OB	Ordered By
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PW	Pick Up Address
QA	Pharmacy
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QS	Podiatrist

			QV	**Group Practice**			
			RW	**Rural Health Clinic**			
			S4	**Skilled Nursing Facility**			
			SJ	**Service Provider**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TU	**Third Party Repricing Organization (TPO)**			
			TV	**Third Party Administrator (TPA)**			
			UH	**Nursing Home**			
			X5	**Durable Medical Equipment Supplier**			
NOT USED	**STC02**	**373**	**Date**		**O**	**DT**	**6/6**
SITUATIONAL	**STC03**	**306**	**Action Code** Code indicating type of action		**O**	**ID**	**1/2**
			CODE	DEFINITION			
			15	**Correct and Resubmit Claim**			
			NA	**No Action Required**			
SITUATIONAL	**STC04**	**782**	**Monetary Amount** Monetary amount ADVISORY: Under most circumstances, this element is expected to be sent. SEMANTIC: STC04 is the amount of original submitted charges.		**O**	**R**	**1/15**
			Amount of original submitted charges.				
NOT USED	**STC05**	**782**	**Monetary Amount**		**O**	**R**	**1/15**
NOT USED	**STC06**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC09**	**429**	**Check Number**		**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line SEMANTIC NOTES 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.		**O**		
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list CODE SOURCE **507:** Health Care Claim Status Category Code	**M**	**AN**	**1/30**
REQUIRED	**STC10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list CODE SOURCE **508:** Health Care Claim Status Code	**M**	**AN**	**1/30**
SITUATIONAL	**STC10 - 3**		**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O**

Used to convey status of the entire claim or a specific service line

SEMANTIC NOTES

01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).

02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508).

03 C043-03 identifies the entity associated with the Health Care Claim Status Code.

REQUIRED **STC11 - 1** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M** **AN** **1/30**

Code indicating a code from a specific industry code list

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC11 - 3** **98** **Entity Identifier Code** **O** **ID** **2/3**

Code identifying an organizational entity, a physical location, property or an individual

SITUATIONAL **STC12** **933** **Free-Form Message Text** **O** **AN** **1/264**

Free-form message text

ADVISORY: Under most circumstances, this element is not sent.

SEMANTIC: STC12 allows additional free-form status information.

The use of this text field is limited to two specific situations. The first situation where it is acceptable to use this data element is in conjunction with Health Care Claim Status Code 448 for rejection error messages. The second situation where it is acceptable to use this data element is for periods of time when a new error rejection condition exists and the assignment of a Health Care Claim Status Code is pending. This condition should only exist between meetings of the Claims Adjustment and Claim Status Reason Code committee which maintain code lists 507 and 508 as referenced in Appendix C of this guide.

The authors strongly urge that the improper use of this field will dilute this functionality of the transaction's business purpose.

IMPLEMENTATION

SERVICE LINE ITEM CONTROL NUMBER

Loop: **2220D — SERVICE LINE INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Used if Patient is subscriber.**

Example: **REF*FJ*SMITH-J-96042201~**

STANDARD

REF Reference Identification

Level: Detail

Position: 200

Loop: 2220

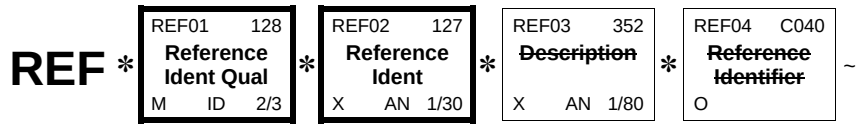
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION **FJ — Line Item Control Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE LINE DATE

Loop: **2220D — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 210

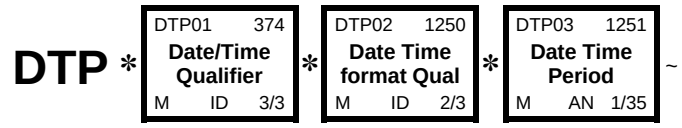
Loop: 2220

Requirement: Optional

Max Use: 1

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			CODE **DEFINITION** **472** **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **RD8** **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M AN 1/35**

IMPLEMENTATION

DEPENDENT

Loop: **2000E — DEPENDENT** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

2. **Required when the patient is not the same entity as subscriber.**

Example: **HL*5*4*23~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

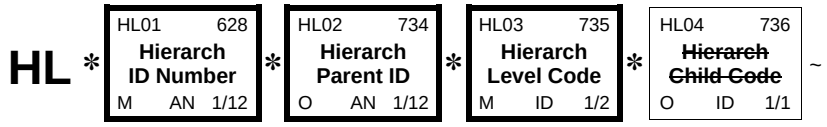
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to **COMMENT:** HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**

REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M**	**ID**	**1/2**

CODE	DEFINITION
23	**Dependent**

NOT USED	**HL04**	**736**	**Hierarchical Child Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PATIENT NAME

Loop: **2100E — PATIENT NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*SMITH*JOSEPH****MI*012345678-02~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 050

Loop: 2100 **Repeat:** >1

Requirement: Optional

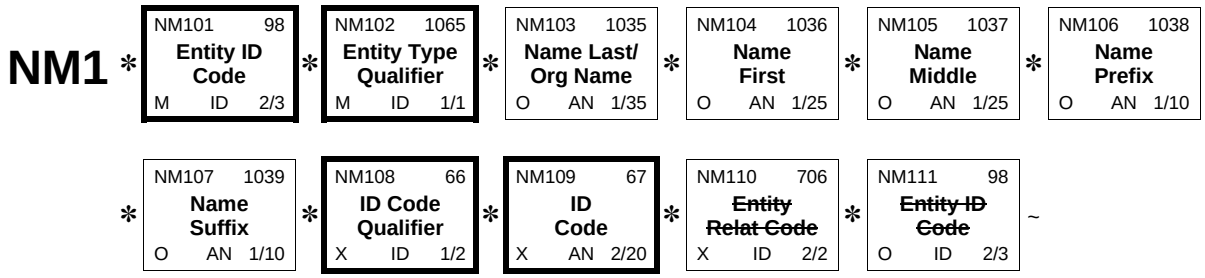
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE: **QC** — DEFINITION: **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE: **1** — DEFINITION: **Person**	

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **ADVISORY:** Under most circumstances, this element is expected to be sent.	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **ADVISORY:** Under most circumstances, this element is expected to be sent. **This Information should always be returned when supplied on a submitted claim.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **This Information should always be returned when supplied on a submitted claim.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809	**X**	**AN**	**2/20**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

CODE	DEFINITION
CI	**CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) Identification Number**
MI	**Member Identification Number**
MR	**Medicaid Recipient Identification Number**
N	**Insured's Unique Identification Number**

IMPLEMENTATION

PATIENT ADDRESS

Loop: **2100E — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Advisory: **Under most circumstances, this segment is not sent.**

Example: **N3*123 MAIN STREET~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

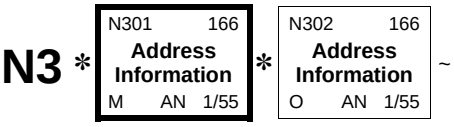
Loop: 2100

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			Used when second line of address is necessary.			

IMPLEMENTATION

PATIENT CITY/STATE/ZIP

Loop: **2100E — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Advisory: **Under most circumstances, this segment is not sent.**

Example: **N4*MIAMI*FL*33131~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

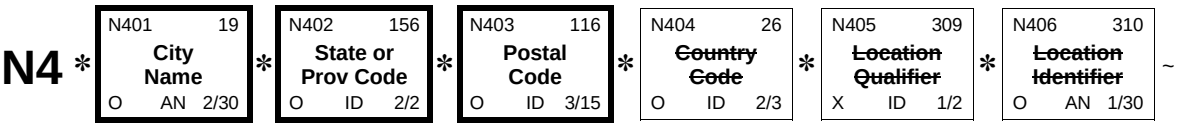
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) **CODE SOURCE 51:** ZIP Code	**O ID 3/15**
NOT USED	**N404**	**26**	**Country Code**	**O ID 2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X ID 1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O AN 1/30**

IMPLEMENTATION

CLAIM SUBMITTER'S IDENTIFIER

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Example: **TRN*2*SMITH123~**

STANDARD

TRN Trace

Level: Detail

Position: 090

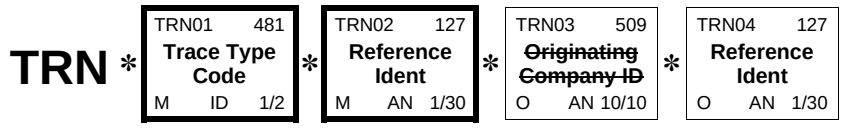
Loop: 2200 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To uniquely identify a transaction to an application

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced CODE / DEFINITION **2 — Referenced Transaction Trace Numbers**	**M ID 1/2**
REQUIRED	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: TRN02 provides unique identification for the transaction. **Provider's Patient Control number as supplied by originator of claim. From : Paper UB92 - Form Locator 3. UB92 Flat File Record type 20 field-03. Paper 1500 - Block 26. ANSI 837 - CLM01. NSF - CA0-03.**	**M AN 1/30**
NOT USED	**TRN03**	**509**	**Originating Company Identifier**	**O AN 10/10**

SITUATIONAL **TRN04** **127** **Reference Identification** **O AN 1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SEMANTIC: TRN04 identifies a further subdivision within the organization.

Some multiple-line of business claim payer systems require codes to indicate the line of business for which a particular claim is being routed. This is accomplished in the ASC X12N 3070 837 SBR09 data element 1032. The NSF format utilizes CA0-23.0. The HCFA 1500 paper form utilizes Block 1. The UB92 Paper form Locator 50 indicates this information, and the UB92 electronic format Record 30 field 4. The following list is a subset of data element 1032. These are values recommended to indicate the appropriate line of business when single file transmissions contain claims for multiple business lines.

10 Central Certification
12 Preferred Provider Organization (PPO)
13 Point ofService (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Risk
17 Dental Maintenance Organization
AM Automobile Medical
BL Blue Cross/Blue Shield
CH Champus
CI Commercial Insurance Co.
DS Disability
FI Federal Employees Program
HM Health Maintenance Organization
LM Liability Medical
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MH Managed Care Non-HMO
OF Other Federal Program
SA Self-administered Group
TV Title V
VA Veteran's Administration
WC Workers' Compensation Health Claim

IMPLEMENTATION

CLAIM LINE STATUS INFORMATION

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use of this segment is required if the subscriber is not the patient.**

Example: **STC*A1:21*960501*NA*50~ or STC*A3:247*960501*15*50~**

STANDARD

STC Status Information

Level: Detail

Position: 100

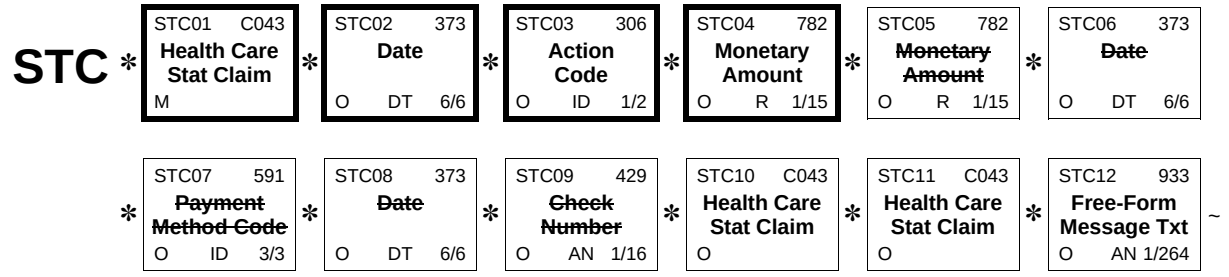
Loop: 2200

Requirement: Mandatory

Max Use: 1

Purpose: To report the status, required action, and paid information of a claim or service line

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** **M** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.	
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	
REQUIRED	**STC01 - 2**	**1271**	**Industry Code** **M AN 1/30** Code indicating a code from a specific industry code list **CODE SOURCE 508:** Health Care Claim Status Code	

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**

Code identifying an organizational entity, a physical location, property or an individual

CODE	DEFINITION
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1I	Preferred Provider Organization (PPO)
1P	Provider
2I	Church Operated Facility
2Q	Veterans Administration Facility
30	Service Supplier
36	Employer
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
CK	Pharmacist
CZ	Admitting Surgeon
DD	Assistant Surgeon
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician
E9	Participating Laboratory
EY	Employee Name
FA	Facility
G0	Dependent Insured

G3	Clinic
G8	Entity Responsible for Follow-up
GI	Paramedic
GJ	Paramedical Company
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
OB	Ordered By
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PW	Pick Up Address
QA	Pharmacy
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist
QS	Podiatrist
QV	Group Practice
RW	Rural Health Clinic
S4	Skilled Nursing Facility

			SJ	**Service Provider**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TU	**Third Party Repricing Organization (TPO)**			
			TV	**Third Party Administrator (TPA)**			
			UH	**Nursing Home**			
			X5	**Durable Medical Equipment Supplier**			
REQUIRED	**STC02**	**373**	**Date** Date (YYMMDD) **SEMANTIC:** STC02 is the effective date of the status information.		**O**	**DT**	**6/6**
			Date of Status				
REQUIRED	**STC03**	**306**	**Action Code** Code indicating type of action		**O**	**ID**	**1/2**
			CODE	**DEFINITION**			
			15	**Correct and Resubmit Claim**			
			NA	**No Action Required**			
REQUIRED	**STC04**	**782**	**Monetary Amount** Monetary amount **SEMANTIC:** STC04 is the amount of original submitted charges.		**O**	**R**	**1/15**
			Amount of original submitted charges.				
NOT USED	**STC05**	**782**	**Monetary Amount**		**O**	**R**	**1/15**
NOT USED	**STC06**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC09**	**429**	**Check Number**		**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.		**O**		
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	**M**	**AN**	**1/30**
REQUIRED	**STC10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 508:** Health Care Claim Status Code	**M**	**AN**	**1/30**
SITUATIONAL	**STC10 - 3**		**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**

SITUATIONAL	**STC11**	**C043**	**HEALTH CARE CLAIM STATUS**		**O**		
			Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.				
REQUIRED	**STC11 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	**M**	**AN**	**1/30**
REQUIRED	**STC11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 508:** Health Care Claim Status Code	**M**	**AN**	**1/30**
SITUATIONAL	**STC11 - 3**		**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**O**	**ID**	**2/3**
SITUATIONAL	**STC12**	**933**	**Free-Form Message Text** Free-form message text **ADVISORY:** Under most circumstances, this element is not sent. **SEMANTIC:** STC12 allows additional free-form status information.		**O**	**AN**	**1/264**

Only used when STC01-2 or STC10-2 or STC11-2 is equal to 448 (invalid billing code combination).

The use of this text field is limited to two specific situations. The first situation where it is acceptable to use this data element is in conjunction with Health Care Claim Status Code 448 for rejection error messages. The second situation where it is acceptable to use this data element is for periods of time when a new error rejection condition exists and the assignment of a Health Care Claim Status Code is pending. This condition should only exist between meetings of the Claims Adjustment and Claim Status Reason Code committee which maintain code lists 507 and 508 as referenced in Appendix C of this guide.

The authors strongly urge that the improper use of this field will dilute this functionality of the transaction's business purpose.

IMPLEMENTATION

PAYER'S CLAIM CONTROL NUMBER

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This is payer's assigned control number and is to be the primary key required during an inquiry.**
2. **Required when used for pended claim list function.**
3. **Advised when available for claims accepted for adjudication.**

Example: **REF*1K*9612991010987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

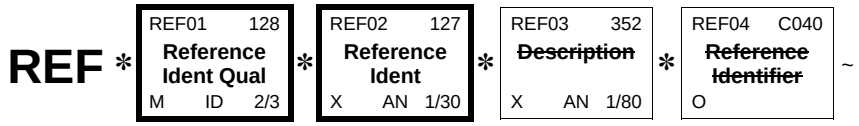
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			For example ICN, DCN, CCN.	
			CODE / DEFINITION	
			1K Payor's Claim Number	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

INSTITUTIONAL TYPE OF BILL

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This is institutional type of bill on original submitted claim and is to be secondary key required during an inquiry.**

Example: **REF*BLT*111~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

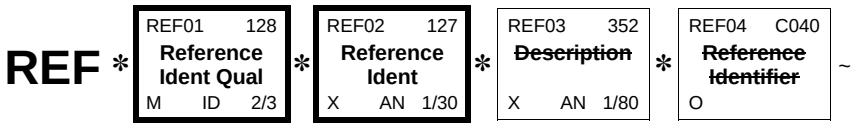
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE: **BLT** — DEFINITION: **Billing Type** **Used on institutional type of bill.**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 **Found in UB92 - Record 40 - Field 4** **Found in UB92 - Paper form locator 4** **Found in X12N 837 Version 3070 Segment CLM Data Element 05** **See C-9 in Appendix C**	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

MEDICAL RECORD NUMBER

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This is the medical record number as submitted on claim and should be returned when available from original claim.**

Example: **REF*EA*J354789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 110

Loop: 2200

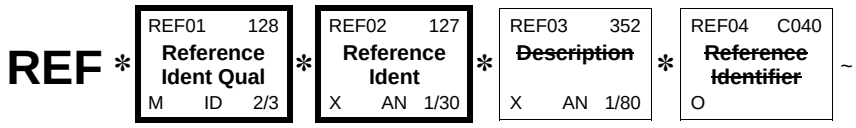
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **EA — Medical Record Identification Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 **Found in UB92 - Record 20 - Field 25** **Found in UB92 - Paper form locator 23** **Found in X12N 837 Version 3070 Loop 2010 Segment REF01 Qualifier EA**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

CLAIM SERVICE DATE

Loop: **2200E — CLAIM SUBMITTER'S IDENTIFIER**

Usage: **SITUATIONAL**

Repeat: **2**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

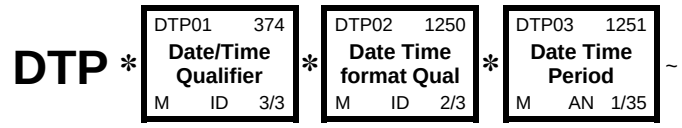
Loop: 2200

Requirement: Optional

Max Use: 2

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			CODE **DEFINITION** **472** **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **RD8** **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M AN 1/35**

IMPLEMENTATION

SERVICE LINE INFORMATION

Loop: **2220E — SERVICE LINE INFORMATION** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Example: **SVC*HC:99214*50*0***1~ or SVC*NU:71X*50*0***1~**

STANDARD

SVC Service Information

Level: Detail

Position: 180

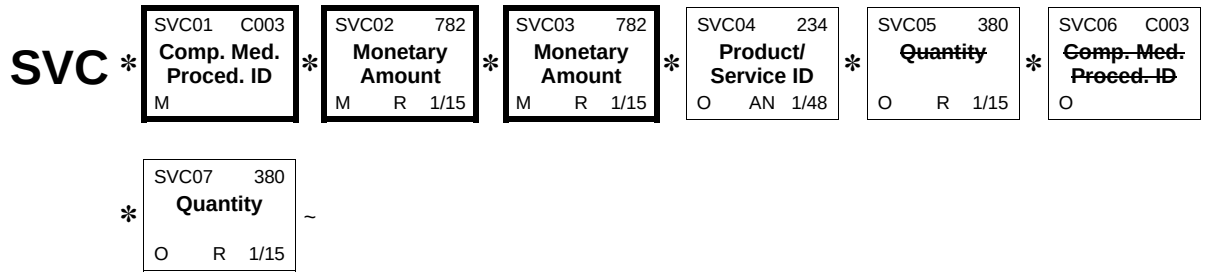
Loop: 2220 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: To supply payment and control information to a provider for a particular service

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVC01**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **SEMANTIC NOTES** 03 C003-03 modifies the value in C003-02. 04 C003-04 modifies the value in C003-02. 05 C003-05 modifies the value in C003-02. 06 C003-06 modifies the value in C003-02. 07 C003-07 is the description of the procedure identified in C003-02.	**M**

REQUIRED **SVC01 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

CODE	DEFINITION
A9	**Health Care Financing Administration National Standard Format Podiatry Codes**
	CODE SOURCE **265:** Health Care Financing Administration National Standard Format Podiatry Codes
AD	**American Dental Association Codes**
	CODE SOURCE **135:** American Dental Association Codes
CI	**Common Language Equipment Identifier (CLEI)**
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ND	**National Drug Code (NDC)**
	CODE SOURCE **134:** National Drug Code
NU	**National Uniform Billing Committee (NUBC) UB92 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes
RB	**National Uniform Billing Committee (NUBC) UB82 Codes**
	CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED **SVC01 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

SITUATIONAL **SVC01 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL **SVC01 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

NOT USED **SVC01 - 7** **352** **Description** **O AN 1/80**

REQUIRED	**SVC02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/15**
			SEMANTIC: SVC02 is the submitted service charge.			
			This is submitted charge.			
REQUIRED	**SVC03**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/15**
			SEMANTIC: SVC03 is the amount paid this service.			
			Must equal zero.			
			This is the amount paid.			
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**AN**	**1/48**
			SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code.			
			When SVC01-1 is equal to "NU" the NUBC Revenue Code belongs in SVC01-2.			
NOT USED	**SVC05**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**SVC06**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
SITUATIONAL	**SVC07**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**
			ADVISORY: Under most circumstances, this element is expected to be sent.			
			SEMANTIC: SVC07 is the original submitted units of service.			
			This is the submitted units of service.			

IMPLEMENTATION

SERVICE LINE STATUS INFORMATION

Loop: **2220E — SERVICE LINE INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **STC*A3:110**15*65~ or STC*A3:249**15*65******A3:400~**

STANDARD

STC Status Information

Level: Detail

Position: 190

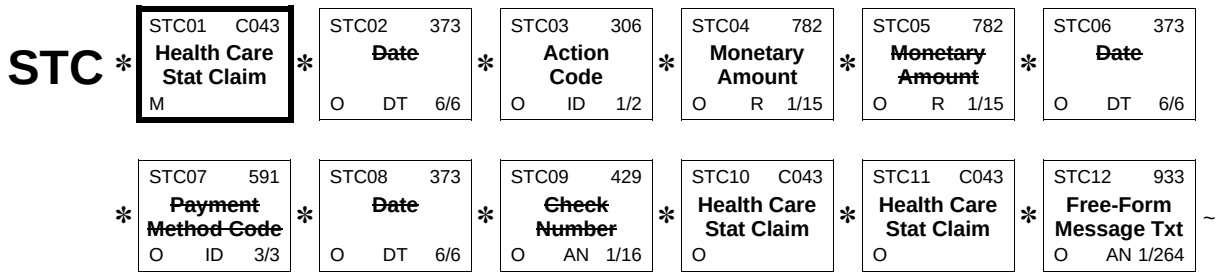
Loop: 2220

Requirement: Mandatory

Max Use: 1

Purpose: To report the status, required action, and paid information of a claim or service line

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**STC01**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code. **ADVISORY:** Under most circumstances, this composite is expected to be sent.	**M**
REQUIRED	**STC01 - 1**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **ADVISORY:** Under most circumstances, this component is expected to be sent **CODE SOURCE 507:** Health Care Claim Status Category Code	**M AN 1/30**

REQUIRED **STC01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

ADVISORY: Under most circumstances, this component is expected to be sent

CODE SOURCE **508:** Health Care Claim Status Code

SITUATIONAL **STC01 - 3** **98** **Entity Identifier Code** **O ID 2/3**
Code identifying an organizational entity, a physical location, property or an individual

ADVISORY: Under most circumstances, this component is expected to be sent

CODE	DEFINITION
17	Consultant's Office
1E	Health Maintenance Organization (HMO)
1I	Preferred Provider Organization (PPO)
1P	Provider
2I	Church Operated Facility
2Q	Veterans Administration Facility
30	Service Supplier
36	Employer
6Y	Case Manager
71	Attending Physician
72	Operating Physician
73	Other Physician
74	Corrected Insured
80	Hospital
82	Rendering Provider
84	Subscriber's Employer
85	Billing Provider
87	Pay-to Provider
CK	Pharmacist
CZ	Admitting Surgeon
DD	Assistant Surgeon
DK	Ordering Physician
DN	Referring Provider
DO	Dependent Name
DQ	Supervising Physician

E9	Participating Laboratory
EY	Employee Name
FA	Facility
G0	Dependent Insured
G3	Clinic
GB	Other Insured
GI	Paramedic
GJ	Paramedical Company
HF	Healthcare Professional Shortage Area (HPSA) Facility
HH	Home Health Agency
I3	Independent Physicians Association (IPA)
IL	Insured or Subscriber
IN	Insurer
LI	Independent Lab
OB	Ordered By
P0	Patient Facility
P2	Primary Insured or Subscriber
P3	Primary Care Provider
P4	Prior Insurance Carrier
P6	Third Party Reviewing Preferred Provider Organization (PPO)
P7	Third Party Repricing Preferred Provider Organization (PPO)
PW	Pick Up Address
QA	Pharmacy
QC	Patient
QD	Responsible Party
QE	Policyholder
QH	Physician
QK	Managed Care
QL	Chiropractor
QN	Dentist

			QS	**Podiatrist**			
			QV	**Group Practice**			
			RW	**Rural Health Clinic**			
			S4	**Skilled Nursing Facility**			
			SJ	**Service Provider**			
			TQ	**Third Party Reviewing Organization (TPO)**			
			TU	**Third Party Repricing Organization (TPO)**			
			TV	**Third Party Administrator (TPA)**			
			UH	**Nursing Home**			
			X5	**Durable Medical Equipment Supplier**			
NOT USED	**STC02**	**373**	**Date**		**O**	**DT**	**6/6**
SITUATIONAL	**STC03**	**306**	**Action Code** Code indicating type of action		**O**	**ID**	**1/2**
			CODE	**DEFINITION**			
			15	**Correct and Resubmit Claim**			
			NA	**No Action Required**			
SITUATIONAL	**STC04**	**782**	**Monetary Amount** Monetary amount **ADVISORY:** Under most circumstances, this element is expected to be sent. **SEMANTIC:** STC04 is the amount of original submitted charges.		**O**	**R**	**1/15**
			Amount of original submitted charges.				
NOT USED	**STC05**	**782**	**Monetary Amount**		**O**	**R**	**1/15**
NOT USED	**STC06**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC07**	**591**	**Payment Method Code**		**O**	**ID**	**3/3**
NOT USED	**STC08**	**373**	**Date**		**O**	**DT**	**6/6**
NOT USED	**STC09**	**429**	**Check Number**		**O**	**AN**	**1/16**
SITUATIONAL	**STC10**	**C043**	**HEALTH CARE CLAIM STATUS** Used to convey status of the entire claim or a specific service line **SEMANTIC NOTES** 01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507). 02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508). 03 C043-03 identifies the entity associated with the Health Care Claim Status Code.		**O**		
REQUIRED	**STC10 - 1**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 507:** Health Care Claim Status Category Code	**M**	**AN**	**1/30**
REQUIRED	**STC10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list **CODE SOURCE 508:** Health Care Claim Status Code	**M**	**AN**	**1/30**

SITUATIONAL **STC10 - 3** **98** **Entity Identifier Code** **O** **ID** **2/3**
Code identifying an organizational entity, a physical location, property or an individual

SITUATIONAL **STC11** **C043** **HEALTH CARE CLAIM STATUS** **O**
Used to convey status of the entire claim or a specific service line
SEMANTIC NOTES
01 C043-01 is used to specify the logical groupings of Health Care Claim Status Codes (See Code Source 507).
02 C043-02 is used to identify the status of an entire claim or a service line (See Code Source 508).
03 C043-03 identifies the entity associated with the Health Care Claim Status Code.

REQUIRED **STC11 - 1** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

CODE SOURCE 507: Health Care Claim Status Category Code

REQUIRED **STC11 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

CODE SOURCE 508: Health Care Claim Status Code

SITUATIONAL **STC11 - 3** **98** **Entity Identifier Code** **O** **ID** **2/3**
Code identifying an organizational entity, a physical location, property or an individual

SITUATIONAL **STC12** **933** **Free-Form Message Text** **O** **AN** **1/264**
Free-form message text

ADVISORY: Under most circumstances, this element is not sent.

SEMANTIC: STC12 allows additional free-form status information.

The use of this text field is limited to two specific situations. The first situation where it is acceptable to use this data element is in conjunction with Health Care Claim Status Code 448 for rejection error messages. The second situation where it is acceptable to use this data element is for periods of time when a new error rejection condition exists and the assignment of a Health Care Claim Status Code is pending. This condition should only exist between meetings of the Claims Adjustment and Claim Status Reason Code committee which maintain code lists 507 and 508 as referenced in Appendix C of this guide.

The authors strongly urge that the improper use of this field will dilute this functionality of the transaction's business purpose.

IMPLEMENTATION

SERVICE LINE ITEM CONTROL NUMBER

Loop: **2220E — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Advisory: **Under most circumstances, this segment is expected to be sent.**

Example: **REF*FJ*SMITH-J-96040201~**

STANDARD

REF Reference Identification

Level: Detail

Position: 200

Loop: 2220

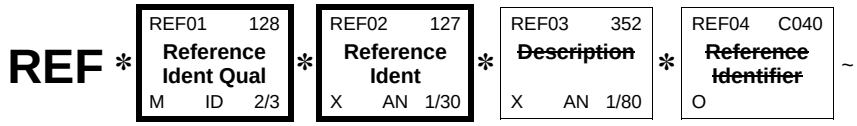
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			FJ **Line Item Control Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE LINE DATE

Loop: **2220E — SERVICE LINE INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Advisory: **Under most circumstances, this segment is expected to be sent.**

Example: **DTP*472*RD8*19960401-19960402~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 210

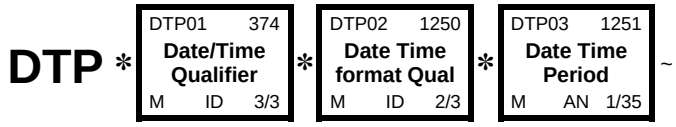
Loop: 2220

Requirement: Optional

Max Use: 1

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			CODE **DEFINITION** **472** **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **RD8** **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M AN 1/35**

IMPLEMENTATION

TRANSACTION TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*40*0001~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 270

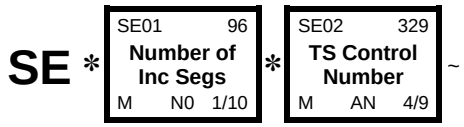
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**

4 EDI Transmission Examples for Different Business Usage

4.1 Scenario One Description

Scenario One depicts the utilization of the ANSI ASC X12 277 in a Medicare Part A, governmental institutional claim environment. Two claims have been electronic transmitted to the Medicare Part A fiscal intermediary through the use of a third party billing service (clearinghouse). In this scenario, one claim has been accepted for submission to the claims adjudication system but has not been paid yet and the other claim is missing a critical piece of required billing information and has been rejected. The provider will have to re-submit the first claim with the invalid information in order to be processed into the adjudication system for payment. The 277 will be returned to the clearinghouse to be returned to the provider in this scenario.

4.1.1 Assumptions

Medicare Part A Fiscal Intermediary, Mutual of Omaha, located at PO Box 4321-9111, Omaha, NB, 54321-9111, has received two electronic ASC X12 837 claims from XYZ Services on behalf of St. Holy Hill Hospital with Provider Number of 3999000B.

St. Holy Hill Hospital utilizes XYZ Services (Electronic Transmitter Identification Number of A222222221), an electronic clearinghouse, to help the hospital prepare and submit its electronic claims to payers.

The first claim submitted is on behalf of Jack J. Jackson of 27065 Ball Road, Anaheim, CA 92658. Mr. Jackson is a Medicare enrollee with a health insurance claim number of 649111111A. The hospital's patient control number is 173170410700.

St. Holy Hill Hospital has submitted a claim for outpatient services (bill type 131) rendered on August 12, 1996 in the amount of $3,775.50.

The second claim submitted is on behalf of Peter M. Jones of 620 Batavia Street, Orange, CA 92868. Mr. Jones is a Medicare enrollee with a health insurance claim number of 123456789A. The hospital's patient control number is 1814771410100.

St. Holy Hill Hospital has submitted a claim for inpatient services (bill type 111) rendered to Mr. Jones from August 7 to August 12, 1996 in the amount of $7,599.00. Mutual of Omaha has assigned a payer internal control number of 960818A347921 to Mr. Jones claim.

Mutual of Omaha's ASC X12 translator has received the ASC X12 837 electronic claims. Mutual of Omaha's translator has validated the syntax of the transmission and has previously confirmed receipt of the claims by sending an ASC X12 997 Acknowledgment to XYZ Services.

Mutual of Omaha's front-end adjudication system editor has reviewed the received claims. The first claim (Jack J. Jackson) has an unacceptable proce-

dure/revenue code for services rendered where the HCPCS code is equal to 80162, revenue code is 320, quantity of 2 and submitted charges are $102.00.

The second claim (Peter M. Jones) had no errors detected by the front-end claims adjudication system editor. Mutual of Omaha sends a code back to the hospital that the claim has been accepted into the adjudication system for payment processing {subject to medical review}.

4.1.2 Transmission

```
ST*277*0001~
BHT*0010*08****TH~
HL*1**20*1~
NM1*PR*2*MUTUAL OF OMAHA*****PI*05440~
N3*PO BOX 4321-9111~
N4*OMAHA*NB*543219111~
HL*2*1*21*1~
NM1*41*2*XYZ SERVICE*****46*A222222221~
HL*3*2*19*1~
NM1*1P*2*ST HOLY HILL HOSPITAL*****SV*3999000B~
HL*4*3*22*0~
N*JACK*J***HN*649111111A~
TRN*2*173170410700~
P*960816*15*3775.50~
REF*BLT*131~
DTP*472*RD8*19960812-19960812~
SVC*HC:80162*102.00*0*320***2~
STC*A3:253~
HL*5*3*22*0~
NM1*QC*1*JONES*PETER*M***HN*123456789A~
TRN*2*1814771410100~
STC*A2:20*NA*7599.00~
REF*1K*960818A347921~
REF*BLT*111~
DTP*472*RD8*19960807-19960812~
SE*26*0001~
```

4.2 Scenario Two Description

Scenario Two depicts the use of the ANSI ASC X12 277 in a commercial insurance Preferred Provider Organization (PPO) claim environment.

4.2.1 Assumptions

ABC Insurance located at PO Box 1234, El Monte, CA 91734-1234 has received an electronic ASC X12 837 institutional claim from XYZ Services on behalf of St. Holy Hill Hospital (Federal Employer Identification Number 95-1234567).

St. Holy Hill Hospital utilizes, XYZ Services (Electronic Transmitter Identification Number of A222222221), an electronic clearinghouse, to help it prepare and submit its electronic claims to payers.

The claim submitted is on behalf of Robert J. Smith of 123 Main Street, Santa Ana, CA 92707. Robert is insured under a health plan sponsored by Corridor Construction Local 699 (Group Number W524 and Member Number 555991234).

The patient is Harriet M. Smith, Robert's wife. Harriet's Member Number is 525224321. Harriet lives with her husband. Harriet's hospital patient control number is 157335210300.

The Smith's have just had a baby girl delivered at St. Holy Hill Hospital. Harriet was admitted on April 1 and discharged on April 3, 1996. The total submitted charges were $2,599.55.

ABC Insurance Company's ASC X12 translator has received the electronic ASC X12 837 claim from XYZ Services. ABC's translator has validated the transmission syntax and has returned an ASC X12 997 Acknowledgment to XYZ Services.

ABC's front-end adjudication system editor has reviewed the claim and found a number of errors. The claim has been rejected by ABC. It must be corrected and re-submitted by the Hospital in order for ABC to accurately pay the claim. The following errors were detected in the claim:

- The claim indicates that the Hospital combined billed the mother and the baby's charges on this claim. ABC Insurance has entered into a PPO contract with St. Holy Hill Hospital which requires the Hospital to separately bill for the mother and the baby's services.
- The institutional claim indicates that for the National Uniform Billing Committee (NUBC) revenue code 720, Labor and Delivery, no submitted charges were reported and the claim is out of balance.
- The claim does not report the PPO's assigned authorization/certification number.

4.2.2 Transmission

```
ST*277*0199~
BHT*0010*08****TH~
HL*1**20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
N3*PO BOX 1234~
N4*EL MONTE*CA*917341234~
```

```
HL*2*1*21*1~
NM1*41*2*XYZ SERVICE*****46*A222222221~
HL*3*2*19*1~
NM1*1P*2*ST HOLY HILL HOSPITAL*****SV*951234567~
HL*4*3*22*1~
NM1*IL*1*SMITH*ROBERT*J***MI*555991234~
HL*5*4*23~
NM1*QC*1*SMITH*HARRIET*M***MI*525224321~
TRN*2*157335210300~
STC*A3:238*960816*15*2599.55~
REF*BLT*111~
DTP*472*RD8*19960401-19960403~
SVC*NU:720*0*0****1~
STC*A3:122**15*0******A3:400*A3:252~
SE*21*0199~
```

4.3 Scenario Three Description

Scenario Three depicts the utilization of the ANSI ASC X12 277 in a Medicare Part A, governmental institutional claim environment and PPO claim environment. Three claims have been electronic transmitted previously to the Medicare Part A fiscal intermediary and the PPO organization through the use of a third party billing service (clearinghouse). In this scenario, three claims are pended when the bi-weekly status report is generated. The first claim is missing a critical piece of required billing information and a request for additional information has been sent to the provider. The second claim has been processed but has not been paid. The third claim is pending waiting for benefit determination. The 277 Pending Status will be returned to the clearinghouse to be returned to the provider in this scenario.

4.3.1 Assumptions

ABC Insurance is both the Medicare Part A Fiscal Intermediary and the PPO organization. ABC Insurance is located at 1 Smith Street, Suite 100, Tampa, FL 99999. ABC Insurance receives all EDI transmissions from XYZ Service on behalf of Hoover Nursing Home with Provider numbers of 155999 for Medicare Part A and 124567890 for the PPO organization.

Hoover Nursing Home utilizes XYZ Service (Electronic Transmitter Identification Number of X67E, an electronic clearinghouse, to help the nursing home prepare and submit its electronic claims to payers.

The first claim submitted is on behalf of Fred Smith. Mr. Smith is a Medicare enrollee with a health insurance claim number of 123456789A. The Nursing Home's patient control number is SMITH123.

Hoover Nursing Home has submitted a claim for impatient services (bill type 211) for services August 31, 1996 - September 6, 1996 in the amount of $8,513.88.

ABC Insurance Co. has assigned a payer internal control number of 1625032606 to Mr. Smith's claim. The claim has suspended for additional information. The request for additional information has been sent to the Nursing Home.

The second claim submitted is on behalf of Mary Jones. Mrs. Jones is a Medicare enrollee with a health insurance claim number of 234567890A. The Nursing Home's patient control number is JONES123.

Hoover Nursing Home has submitted a claim for inpatient services (bill type 211) for services from July 31, 1996 - August 9, 1996 in the amount of $7,599.00.

ABC Insurance Co. has assigned a payer internal control number of 1622241518 to Mrs. Jones claim. The claim has completed processing and will be paid when the payment floor has been met.

The third claim submitted is on behalf of Joseph Mann who is covered as a dependent under John Mann. Joseph Mann is covered under the PPO plan and his member identification is 345678901-02. John Mann is the insured or subscriber and his member identification is 345678901. The Nursing Home's patient control number is MANN123.

Hoover Nursing Home has submitted a claim for inpatient services (bill type 231) for services from May 01, 1996 - May 30, 1996 in the amount of $4,899.50.

ABC Insurance Co. has assigned a payer internal control number of 961681010827 to Mr. Mann's claim. The claim has been pended awaiting benefit determination.

4.3.2 Transmission

```
ST*277*0001~
BHT*0010*08****NO~
HL*1**20*1~
NM1*PR*2*ABC INSURANCE*****PI*12345~
N3*1 SMITH STREET*SUITE 100~
N4*MIAMI*FL*33131~
HL*2*1*21*1~
NM1*41*2*XYZ SERVICE*****46*X67E~
N3*123 MAIN STREET*SUITE 204~
N4*JACKSONVILLE*FL*32225~
HL*3*2*19*1~
NM1*1P*2*HOOVER NURSING HOME*****SV*155999~
HL*4*3*22*0~
NM1*QC*1*SMITH*FRED****HN*123456789A~
TRN*2*SMITH123~
STC*P3:122*960923*8513.88~
REF*1K*1625032606~
REF*BLT*211~
DTP*472*RD8*19960831-19960906~
HL*5*3*22*0~
NM1*QC*1*JONES*MARY****HN*234567890A~
```

```
TRN*2*JONES123~
STC*F0:3*960923*NA*7599~
REF*1K*1622241518~
REF*BLT*211~
DTP*472*RD8*19960731-19960809~
HL*6*2*19*1~
NM1*1P*2*HOOVER NURSING HOME*****SV*124567890~
HL*7*3*22*1~
NM1*IL*1*MANN*JOHN****MI*345678901~
HL*8*4*23*0~
NM1*QC*1*MANN*JOSEPH****MI*345678901-02~
TRN*2*MANN123~
STC*P1:45:QC*960923*NA*4899.5~
REF*1K*961681010827~
REF*BLT*231~
DTP*472*RD8*19960501-19960530~
SE*38*0001~
```

A X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules in order to insure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, zip code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. Using an analogy, the transaction set would be like a freight train, the segments would be the train's cars, and each segment can contain several data elements the same as a train car can hold multiple crates.

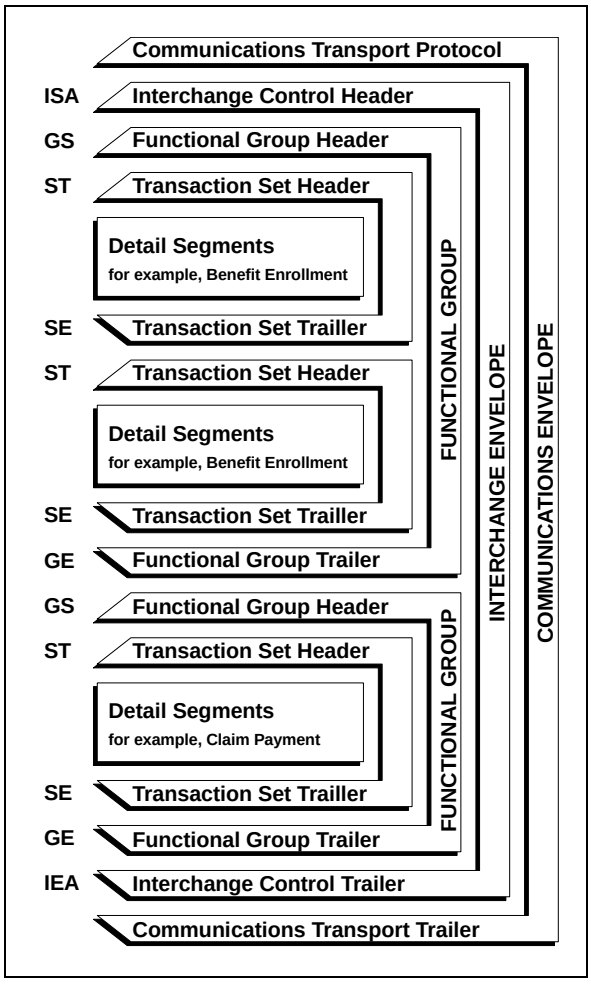


Figure A1. Transmission Control Schematic

The sequence of the elements within one segment is specified by the ASC X12 standard, as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

Similar transaction sets, called functional groups, can be sent together within a transmission. Each functional group is prefaced by a group start segment, and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header, and followed by an interchange trailer. Figure A1 illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions And Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. It is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the usage. The data segment is used primarily to convey user information while the control segment is used primarily to convey control information and for grouping data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Since the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified below.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

It should be noted that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears in other standards such as CCITT S.5. Use of the U.S.A. graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions

from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the following table IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

The Group Separator (GS) may be an exception in this set, since it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4, the component element separator is byte number 105, and the segment terminator is the byte that immediatley follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. During the development of EDI, the historically preferred delimiters have been the asterisk as the data element separator and the new line character as the segment terminator. These two delimiters can be visualized on the printed page and display each segment on a separate line, adding human readability to the transaction set.

For consistency, this implementation guide utilizes the following delimiters in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

- ***NOTE***
  The delimiters above are for illlustration purposes only and are not recommendations.

A.1.3 Business Transaction Structure Definitions And Concepts

The X12 standards define commonly used business transactions (such as a Health Care Claim) in a formal structure called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- Segment Terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The following are data element types that appear in this documentation.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This documentation denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

FOR EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

FOR EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless necessary to satisfy minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the ISO standard date in YYMMDD format in which YY is the year in the century (00 to 99), MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.”

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

FOR EXAMPLE
Transmitted data elements of 4 characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator, and ending with a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, see the section entitled "**X-** Relational" below.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

FOR EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes utilized within Syntax Notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

ST Transaction Set Header, starts a transaction set.

LS Loop Header, starts a bounded loop of data segments but is not part of the loop.

LS Loop Header, starts an inner, nested, bounded loop.

LE Loop Trailer, ends an inner, nested bounded loop.

LE Loop Trailer, ends a bounded loop of data segments but is not part of the loop.

SE Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used, within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See ***Figure A1 — Interchange Control Schematic.***

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the transaction set header segment (ST). A user-assigned transaction set control number in the header must match the control number in the trailer segment (SE) for any given transaction set. The value for the number of included segments in the SE segment, is the total number of segments in the transaction set including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is “>1".

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

In order to establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maxi-

mum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1".

There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start (LS) segment to appear before the first occurrence and a loop end (LE) segment to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by “>1".

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the

functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets, is the total number of transaction sets in the group. See ***Figure A1 — Interchange Control Schematic.***

A.1.4 Envelopes And Control Structures

A.1.4.1 Interchange Control Structures

The term “Interchange” typically connotates the ISA/IEA envelope that is transmitted between trading/business partners. Interchange Control is achieved through several “control” components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products if these fields are different the interchange will be “suspended” in error.

There are many other features of the ISA segment that are utilized for control measures. For instance the ISA segment contains data elements such as authorization information, security information, sender identification and receiver identification that can be utilized for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written Trading Partner Agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are utilized for debugging purposes when there is a problem with the transmission or the interchange. Data Element ISA12, interchange control version number, indicates the version of the ISA/IEA envelope. (Reference the Interchange Overview section of the ASC X12 Concepts and Syntax portion of this document for a further explanation of envelopes). This does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An “Interchange”Acknowledgment, can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a “yes” condition in data element ISA14 would be the TA1 segment. Data Element ISA15, test indicator, is utilized between trading partners to indicate that the transmission is in a “test” or “production” mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is utilized by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrepancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

- See the ***Appendix B, EDI Control Directory*** for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is utilized by the commercial

translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be utilized to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be utilized to identify the receiving unit of the transmission. Relative to health care, this unit identification can be utilized to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be utilized for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. For purposes of this implementation guide the value contained in this data element should be 003041. This does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

- See the ***Appendix B, EDI Control Directory*** for a complete detailing of the functional group header and trailer.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set specific verification is accomplished through utilization of the Functional Acknowledgment Transaction Set, 997. See ***A.1.5.2 Functional Acknowledgment, 997*** for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, the Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, the Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1.

- See the ***Appendix B, EDI Control Directory*** for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a Functional Group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications.

The 997 is typically utilized as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be utilized.

- See ***Appendix B, EDI Control Directory*** for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segmant and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

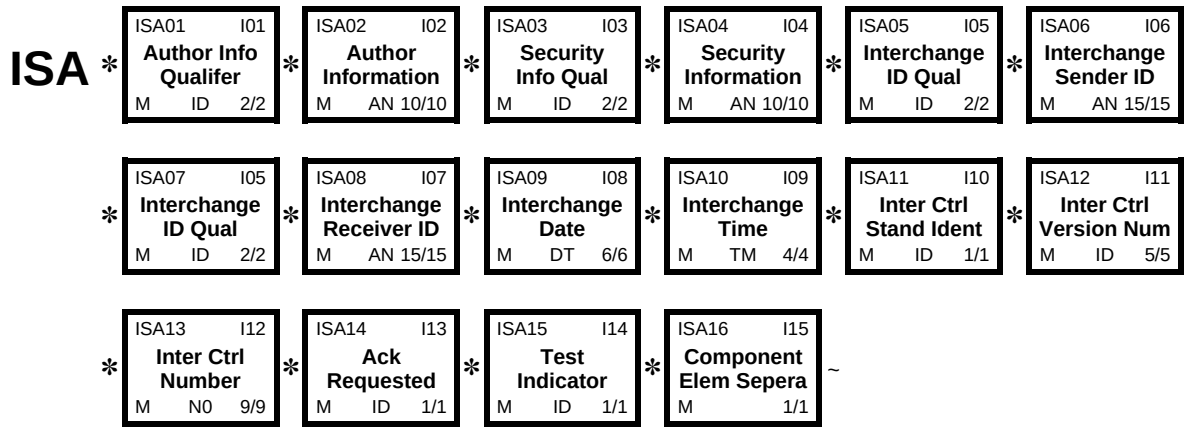
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID...* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00307* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
12	**Phone (Telephone Companies)** **NOT ADVISED**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Identification Number
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
12	**Phone (Telephone Companies)** **NOT ADVISED**
14	**Duns Plus Suffix**

			20	**Health Industry Number (HIN)**			
				CODE SOURCE **121:** Health Industry Identification Number			
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**			
			30	**U.S. Federal Tax Identification Number**			
			33	**National Association of Insurance Commissioners Company Code (NAIC)**			
			ZZ	**Mutually Defined**			
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them		**M**	**AN**	**15/15**
REQUIRED	**ISA09**	**I08**	**Interchange Date** Date of the interchange		**M**	**DT**	**6/6**
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time** Time of the interchange		**M**	**TM**	**4/4**
			The time format is HHMM.				
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier** Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer		**M**	**ID**	**1/1**
			CODE	DEFINITION			
			U	**U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number** This version number covers the interchange control segments		**M**	**ID**	**5/5**
			CODE	DEFINITION			
			00307	**Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1996**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender		**M**	**N0**	**9/9**
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				
REQUIRED	**ISA14**	**I13**	**Acknowledgment Requested** Code sent by the sender to request an interchange acknowledgment (TA1)		**M**	**ID**	**1/1**
			See Section A.1.5.1 for Interchange Acknowledgment Information.				
			CODE	DEFINITION			
			0	**No Acknowledgment Requested**			
			1	**Interchange Acknowledgment Requested**			

REQUIRED **ISA15** **I14** **Test Indicator** **M** **ID** **1/1**

Code to indicate whether data enclosed by this interchange envelope is test or production

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M** **1/1**

Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

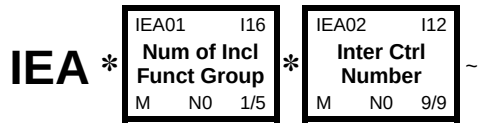
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

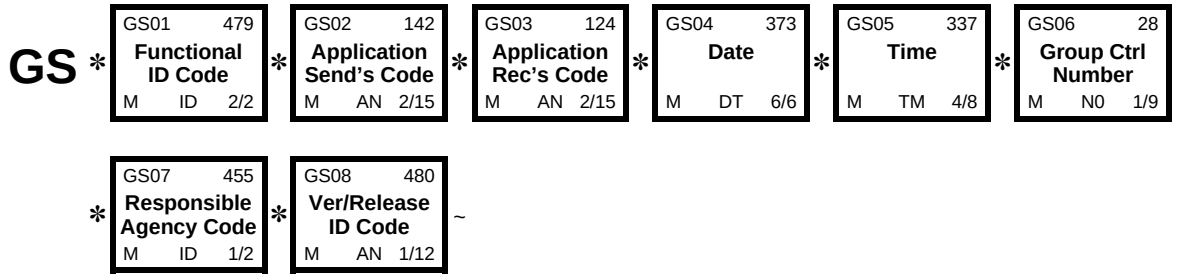
Example: GS*HN*SENDER CODE*RECEIVER CODE*940331*0802*1*X*003070~

STANDARD

GS Functional Group Header

Purpose: To indicate the beginning of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets CODE: **HN** — DEFINITION: **Health Care Claim Status Notification (277)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **The identification code of the unit sending the information.**	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **The identification code for the unit receiving the information.**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date (YYMMDD) **SEMANTIC:** GS04 is the group date. **This is the functional group creation date.**	**M DT 6/6**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time. **Functional group creation time. Recommended format is HHMM.**	**M TM 4/8**

REQUIRED **GS06** **28** **Group Control Number** **M** **N0** **1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

REQUIRED **GS07** **455** **Responsible Agency Code** **M** **ID** **1/2**

Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M** **AN** **1/12**

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

Implementers of this guideline will always send 003051X12N.

CODE	DEFINITION
003070X070	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through February 1996**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

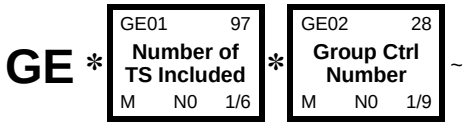
Example: GE*1*1~

STANDARD

GE Functional Group Trailer

Purpose: To indicate the end of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **See Section A.1.5.1 for Interchange Acknowledgment Information.**
2. **All fields must contain data.**
3. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly the TA1 will reflect a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**

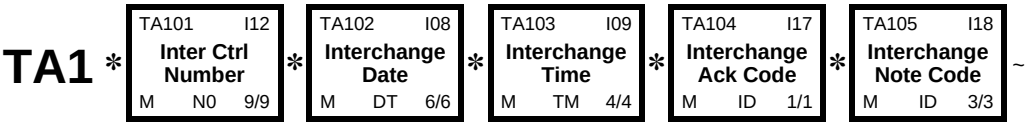
Example: **TA1*000000905*940101*0100*A*001~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain and audit trail of interchanges using this number.			
			In the TA1, this should be the Interchange Control Number of the original interchange that this TA1 is acknowledging.			
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)			
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			This is the time of the original interchange being acknowledged. (HHMM)			

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	**The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.**
E	**The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.**
R	**The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.**

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	**No error**
001	**The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.**
002	**This Standard as Noted in the Control Standards Identifier is Not Supported.**
003	**This Version of the Controls is Not Supported**
004	**The Segment Terminator is Invalid**
005	**Invalid Interchange ID Qualifier for Sender**
006	**Invalid Interchange Sender ID**
007	**Invalid Interchange ID Qualifier for Receiver**
008	**Invalid Interchange Receiver ID**
009	**Unknown Interchange Receiver ID**
010	**Invalid Authorization Information Qualifier Value**
011	**Invalid Authorization Information Value**
012	**Invalid Security Information Qualifier Value**
013	**Invalid Security Information Value**
014	**Invalid Interchange Date Value**
015	**Invalid Interchange Time Value**
016	**Invalid Interchange Standards Identifier Value**
017	**Invalid Interchange Version ID Value**
018	**Invalid Interchange Control Number Value**

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Header

PAGE #	POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
16	010	ST	Transaction Set Header	M	1	
18	020	AK1	Functional Group Response Header	M	1	
			LOOP ID - AK2			999999
19	030	AK2	Transaction Set Response Header	O	1	
			LOOP ID - AK2/AK3			999999
20	040	AK3	Data Segment Note	O	1	
22	050	AK4	Data Element Note	O	99	
24	060	AK5	Transaction Set Response Trailer	M	1	
26	070	AK9	Functional Group Response Trailer	M	1	
28	080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntatical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

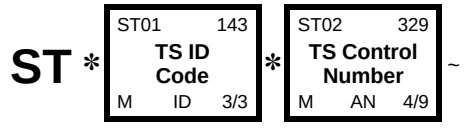
Set Notes:

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

Semantic:

1 The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the invoice transaction set).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set.	**M**	**ID**	**3/3**

CODE	DEFINITION
997	**X12.20 Functional Acknowledgment**

REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.

Use the corresponding value in ST02 for this transaction set.

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEAD

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HN*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

Max Use: 1

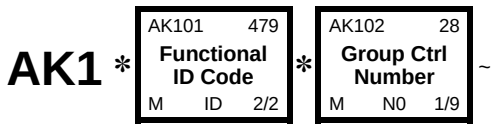
Purpose: To start acknowledgment of a functional group.

Set Notes:
1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

Semantic:
1 AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.

2 AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related Transaction Sets.	**M**	**ID**	**2/2**
			CODE / **DEFINITION** **HN** — **Health Care Claim Status Notification (277)**			
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender.	**M**	**N0**	**1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **TRANSACTION SET RESPONSE HEADER** **Repeat:** **999999**

Usage: **OPTIONAL**

Repeat: **1**

Example: **AK2*277*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

Requirement: Optional

Max Use: 1

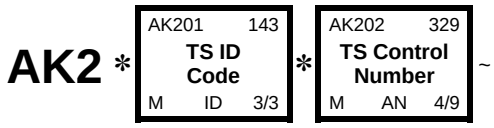
Purpose: To start acknowledgment of a single transaction set.

Set Notes:
1. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

Semantic:
1 AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.

2 AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set.	**M**	**ID**	**3/3**
			CODE / DEFINITION			
			277 **Health Care Claim Status Notification**			
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **OPTIONAL**

Repeat: **1**

Example: **AK3*NM1*37*CLP*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

Requirement: Optional

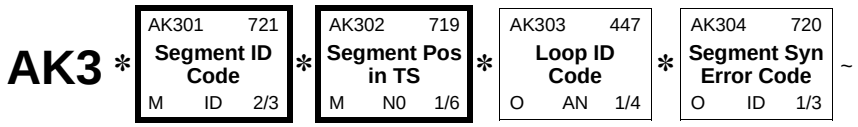
Max Use: 1

Purpose: To report errors in a data segment and to identify the location of the data segment.

Set Notes:

1. The data segments of this standard are used to report the results of the syntatical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error. See Appendix A - Number 77. **This is the 2 or 3 characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1. **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

OPTIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/4**

The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Code identifying a loop within the transaction set which is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

OPTIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**

Code indicating error found based on the syntax editing of a segment

Required if error exists

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **DATA SEGMENT NOTE**

Usage: **OPTIONAL**

Repeat: **99**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

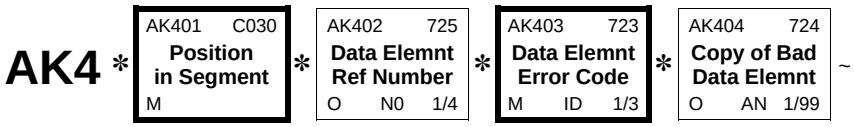
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element and to identify the location of the data element.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
OPTIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error	**O N0 1/2**
ADVISED	**AK402**	**725**	**Data Element Reference Number** Reference number used to locate the data element in the Data Element Dictionary.	**O N0 1/4**
			The Data Element Reference Number for this data element is 725. All reference numbers are found with the segment descriptions in this guide.	

REQUIRED	**AK403**	**723**	**Data Element Syntax Error Code** Code indicating the error found after syntax edits of a data element.	**M**	**ID**	**1/3**

CODE	DEFINITION
1	**Mandatory data element missing**
2	**Conditional required data element missing.**
3	**Too many data elements.**
4	**Data element too short.**
5	**Data element too long.**
6	**Invalid character in data element.**
7	**Invalid code value.**
8	**Invalid Date**
9	**Invalid Time**
10	**Exclusion Condition Violated**

OPTIONAL	**AK404**	**724**	**Copy of Bad Data Element** This is a copy of the data element in error.	**O**	**AN**	**1/99**

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

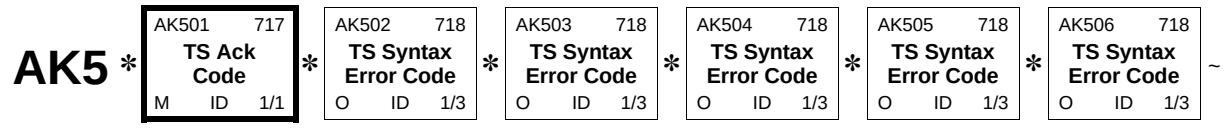
Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and to report errors in a transaction set.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set.	**M ID 1/1**
			CODE / **DEFINITION** **A** — **Accepted ADVISED** **E** — **Accepted But Errors Were Noted** **R** — **Rejected ADVISED**	
OPTIONAL	**AK502**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set. **Required if error exists**	**O ID 1/3**
			CODE / **DEFINITION** **1** — **Transaction Set Not Supported** **2** — **Transaction Set Trailer Missing**	

			3	**Transaction Set Control Number in Header and Trailer Do Not Match**			
			4	**Number of Included Segments Does Not Match Actual Count**			
			5	**One or More Segments in Error**			
			6	**Missing or Invalid Transaction Set Identifier**			
			7	**Missing or Invalid Transaction Set Control Number**			
			23	**Transaction Set Control Number Not Unique within the Functional Group**			
OPTIONAL	**AK503**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set.		**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.				
OPTIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set.		**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.				
OPTIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set.		**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.				
OPTIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set.		**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.				

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9*A*1*1*1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

Loop: ____

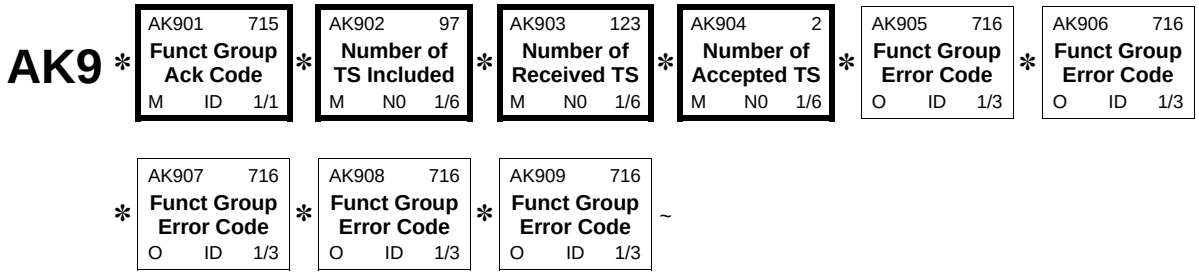
Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group.

Comments: **A** If AK901 is 'A' or 'E', then the transmitted functional group is accepted. If AK901 is 'R', then the transmitted group is rejected.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**

			R	**Rejected**		
				ADVISED		
REQUIRED	**AK902**	**97**	**Number of Transaction Sets Included**	**M**	**N0**	**1/6**
			Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.			
			This is the value in the original GE01.			
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets**	**M**	**N0**	**1/6**
			Number of Transaction Sets received.			
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets**	**M**	**N0**	**1/6**
			Number of accepted Transaction Sets in a Functional Group.			
OPTIONAL	**AK905**	**716**	**Functional Group Syntax Error Code**	**O**	**ID**	**1/3**
			Code indicating error found based on the syntax editing of the functional group header and/or trailer.			
			Required if error exists			
			CODE	**DEFINITION**		
			1	**Functional Group Not Supported**		
			2	**Functional Group Version Not Supported**		
			3	**Functional Group Trailer Missing**		
			4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**		
			5	**Number of Included Transaction Sets Does Not Match Actual Count**		
			6	**Group Control Number Violates Syntax**		
OPTIONAL	**AK906**	**716**	**Functional Group Syntax Error Code**	**O**	**ID**	**1/3**
			Code indicating error found based on the syntax editing of the functional group header and/or trailer.			
			Use the same codes indicated in AK905.			
OPTIONAL	**AK907**	**716**	**Functional Group Syntax Error Code**	**O**	**ID**	**1/3**
			Code indicating error found based on the syntax editing of the functional group header and/or trailer.			
			Use the same codes indicated in AK905.			
OPTIONAL	**AK908**	**716**	**Functional Group Syntax Error Code**	**O**	**ID**	**1/3**
			Code indicating error found based on the syntax editing of the functional group header and/or trailer.			
			Use the same codes indicated in AK905.			
OPTIONAL	**AK909**	**716**	**Functional Group Syntax Error Code**	**O**	**ID**	**1/3**
			Code indicating error found based on the syntax editing of the functional group header and/or trailer.			
			Use the same codes indicated in AK905.			

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **MANDATORY**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

Loop: ____

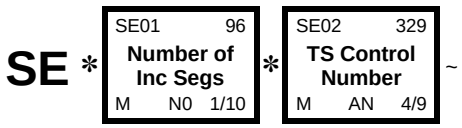
Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).

Comments: **A** SE is the last segment of each transaction set.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments.	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**
			The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	

C External Code Sources

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche available from NTIS (same as address above). The Canadian Post Office lists the following as “official” codes for Canadian Provinces: AB - Alberta BC - British Columbia MB - Manitoba NB - New Brunswick NF - Newfoundland NS - Nova Scotia NT - North West Territories ON - Ontario PE - Prince Edward Island PQ - Quebec SK - Saskatchewan YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a

block, a floor of a building, or a cluster of mailboxes. The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

70 Voluntary Interindustry Communications Standards (VICS)

SIMPLE DATA ELEMENT/CODE REFERENCES

559/VI, 1271

SOURCE

VICS Implementation Guidelines for EDI

AVAILABLE FROM

Uniform Code Council, Inc.
8163 Yankee Road, Suite J
Dayton, OH 45459

ABSTRACT

Conventions and implementation guidelines for electronic data interchange utilizing the ASC X12 Standards within the retail industry.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

SOURCE

Health Industry Number Database

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT

The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospitals and other provider organizations - the customers of health industry manufacturers and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/RB, 235/NU, 1270/BE, 1270/BG, 1270/BH, 1270/BI

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.

134 National Drug Code

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ND, 1270/NDC

SOURCE

Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM

First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT

The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee
American Hospitial Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Category Code

AVAILABLE FROM

The Blue Cross Blue Shield Association
Interplan Teleprocessing Services Division
676 North St. Clair Street
Chicago, IL 60611

ABSTRACT

Code used to organize the Health Care Claim Status Codes into logical groupings

508 Health Care Claim Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Code

AVAILABLE FROM

The Blue Cross Blue Shield Association
Interplan Teleprocessing Services Division
676 North St. Clair Street
Chicago, IL 60611

ABSTRACT

Code identifying the status of an entire claim or service line

540 Health Care Financing Administration National PAYERID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PAYERID Database

AVAILABLE FROM

Health Care Financing Administration
Bureau of Program Operations
Chief, Benefit Coordination
S1-03-08
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Health Care Financing Administration has joined with other payers to develop a unique national payer identification number. The Health Care Financing Administration is the authorizing agent for enumerating payers through the services of a PAYERID Registrar. It may also be used by other payers on a voluntary basis.

D Change Summary

This is the first ASC X12N Implementation Guide for the Unsolicited Claim Status Notification business use of the 277. In future guides, this section will contain a summary and detail of all changes since the previous guide.